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Home Visiting for Pregnant and Parenting Youth in Care: Final Report

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Abstract

This report presents findings from the evaluation of a pilot that aimed to connect pregnant and parenting youth in care with home visiting services. Nine Healthy Families Illinois (HFI) programs participated in the pilot. Those programs provided home visiting services to 43 youth in care who were pregnant or who had a child under age one at the time they enrolled. We found that home visiting services can be provided to pregnant and parenting youth in care and that pregnant and parenting youth in care benefit from those services. However, we also found that engaging and delivering home visiting services to these youth presents multiple challenges. The results of this evaluation have implications for the expansion of home visiting services to pregnant and parenting youth throughout Illinois and to other child welfare populations. It also has implications for the provision of home visiting services as part of the implementation of the Family First Prevention Services Act, not only in Illinois but also in other states.

Executive Summary

This report presents findings from the evaluation of a pilot that aimed to connect pregnant and parenting youth in care with home visiting services. The evaluation used three types of data: program data collected from home visitors and doulas; qualitative interview data collected from home visitors, doulas, supervisors and parents; and, child welfare administrative data.

Nine Healthy Families Illinois (HFI) programs participated in the pilot between November 2016 and March 2019. The programs provided home visiting services to 43 youth in care who were pregnant or who had a child under age one at the time they enrolled. All of the pilot clients were female and their average age at enrollment was 18 years old.

On average, clients were enrolled in the pilot for 362 days. Sixty-six percent of the attempted visits reported by home visitors and doulas were completed. Home visitors and doulas engaged in a wide variety of activities with their clients during those visits. The activities home visitors and doulas engaged in most often were observing clients interacting with their babies, promoting healthy behaviors, promoting secure attachment and providing child development education.

A major goal of the pilot was to promote collaboration between home visiting programs and the child welfare system. Although there was some communication between the HFI program staff and child welfare workers and HFI program staff did attend some child welfare team meetings, the level of collaboration was far lower than expected.

Pregnant and parenting youth in care were chosen as the pilot's target population in part because research has found a high rate of child maltreatment among young parents in care. The results of our analysis of the child welfare data are consistent with the findings from these studies. Seventeen pilot clients were the subject of a child maltreatment investigation involving their child and 11 had at least one indicated allegation while they were enrolled in the pilot. Most of the allegations for which pilot clients were investigated involved neglect and most of the indicated allegations involved neglect, especially substantial risk of physical injury or inadequate supervision

Several major themes emerged from our interviews with the parents who participated in the pilot and with home visitors, doulas and supervisors from the participating HFI programs.

> *Factors influencing engagement.* Several factors influenced young people's decision to engage in home visiting services. These included the voluntary nature of home visiting services, the promise of confidentiality, the dependability of their doulas and home visitors, their need for parenting education, and their desire for baby items.

Building trusting relationships is challenging but key. The home visitor-client relationship is central to the HFI model and pilot clients grew to trust their home visitors and doulas although they were sometimes slow to open up.

Need for a Natural Support System. Many pilot clients lacked a natural support system. Home visitors and doulas filled roles that these natural supports otherwise would.

Benefits of home visiting services. Pilot clients benefitted from the services they received from their home visitors and doulas in a number of different ways. They learned about childbirth, child development and parenting. They also developed coping skills and some of the clients developed positive relationships with the fathers of their babies.

Factors complicating youth engagement and service delivery. Two factors--placement instability and personal crises-- had an adverse impact on engagement and service delivery. Although some pilot clients had relatively stable placements while they were enrolled, others changed placements multiple times. Many pilot clients also experienced one or more non-placement events, such as detention, hospitalization or running away, that disrupted their placements. Personal crises related to mental health problems and intimate partner violence also hindered the delivery of home visiting services.

Navigating the child welfare system is challenging for home visitors. Despite attending a cross-training designed, in part, to familiarize HFI program staff with the child welfare system, home visitors and doulas still had many questions about how DCFS works and about the services and resources available to their pilot clients. Information sharing is a complicated issue for HFI program staff. They disagreed about the importance of knowing about a pilot client's background but agreed that other information was essential to their jobs. HFI program staff also raised concerns about sharing information about their pilot clients with child welfare workers and about their role in child welfare team meetings. Working with pilot clients in congregate care posed an additional set of challenges and prevented some HFI programs from delivering services as usual.

Variation in the ability of programs to work with this population. Factors such as the state budget impasse and staff turnover affected the ability of HFI programs to work with this population. The willingness of HFI programs to accommodate this population's unique needs also affected the extent to which they were able to keep their pilot clients engaged.

Maintaining fidelity to the HFI model can be a challenge. Home visitors and doulas often deviated from what they typically do to engage and deliver services to their pilot clients. These deviations stemmed from several factors including difficulties enrolling youth in the pilot, the need of pilot clients for extra support, the HFI level system, which dictates how often clients are seen, and working with pilot clients whose children were in DCFS care.

Home visitors and doulas routinely exceeded expectations. Home visitors and doulas frequently went "above and beyond" what they were expected to do to meet the needs of their clients. Pilot clients interpreted this as evidence that their home visitors and doulas "genuinely care."

*Supports for home visitors and doulas***.** All of the HFI programs that participated in the pilot had access to infant mental health consultants and FAN training. Both were helpful to home visitors and doulas in their work with pilot clients.

The Family First Prevention Services Act (FFPSA) has the potential to increase access to home visiting services among pregnant and parenting youth in care and other child welfare system involved families, not only in Illinois but also in other states. However, the results of our evaluation suggest that neither engagement nor service delivery will be easy. The lessons we learned from the pilot can help state (and where relevant, county) child welfare agencies plan for and address the challenges they are likely to face with engaging and delivering home visiting services to FFPSA-eligible populations.

In September 2018, about six months before the pilot ended, the national organization, Healthy Families America, rolled out an optional child welfare adaptation of its HFA model. Programs that choose to implement the adaption can enroll families referred by the child welfare system until the target child is 2 years old. The guidance issued by HFA includes both recommendations that closely aligned with lessons learned from the pilot and prohibitions related to issues that the pilot raised.

The pilot was always intended to be a launching pad for a more expansive effort to deliver home visiting services not to just pregnant and parenting youth in care, but to other child welfare involved families throughout Illinois. Although the pilot laid a solid foundation for this expansion, several major issues will need to be addressed for a successful expansion to occur. These issues include training for home visiting program staff and child welfare workers; balancing the different approaches that home visiting programs and child welfare systems take to working with children, youth and families; the development and implementation of policies related to information sharing between home visiting programs and child welfare workers; and the creation of an infrastructure with the capacity to monitor service delivery and troubleshoot when services are not consistently delivered.

Introduction and Background

In January 2015, the Home Visiting Task Force, a standing committee of the Illinois Early Learning Council, established a Home Visiting-Child Welfare Sub-Committee to design and implement a pilot project that would connect pregnant and parenting youth in foster care with home visiting services. The Illinois Department of Children and Family Services contracted with Chapin Hall to evaluate the project. This report presents the results of that evaluation.

Motivation for the Pilot

Research indicates that female foster youth are much more likely to become pregnant and to begin parenting while in their teens than their non-foster peers. They are also more likely to experience a repeat pregnancy, and hence, to be parenting multiple children at an early age.[1] Second, many adolescent parents lack adequate knowledge about child development. This can lead to unrealistic expectations and make it difficult for teenage parents to recognize and appropriately respond to their children's needs and feelings.[2,3,4] For youth in foster care, this lack of knowledge may be compounded by the developmental impacts of the abuse, neglect, or other trauma they have experienced as well as the absence of positive and stable parenting during childhood.

Third, research suggests that children born to teenage mothers are at an increased risk of child abuse and/or neglect compared with children whose mothers were older when their first child was born.[5,6] One study that used aggregate birth certificate data and data from the Integrated Database on Child and Family Programs in Illinois found that the incidence of substantiated child maltreatment by age five was 2.7 times higher among children whose mothers were under age 18 (~11 percent) and 2.3 times higher among children whose mothers were 18 or 19 years

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1 Dworsky, A. (2018). The sexual and reproductive health of youth in foster care. In Elizabeth Trejos and Nancy Trevino (Eds.), *Handbook of foster youth*. New York: Routledge/Taylor and Francis.

2 Borkowski, J., Whitman, T., Farris, J., Carothers, S., Keogh, D., & Weed, K. (2007). *Risk and resilience: Teen mothers and their children grow up*. Mahwah, NJ: Lawrence Erlbaum.

3 Noria, C. W., Weed, K., & Keogh, D. (2007). The fate of adolescent mothers. In J. G. Borkowski, J. R. Farris, T. L. Whitman, S. S. Carothers, K. Weed, & D. A. Keogh (Eds.), *Risk and resilience: Adolescent mothers and their children grow up* (pp. 35–68). Mahwah, NJ: Lawrence Erlbaum Associates.

4 Coley, R., & Chase-Lansdale, P. (1998). Adolescent pregnancy and parenthood: Recent evidence and future directions. *American Psychologist, 53,* 152–166.

5 Connelly, C., & Straus, M. (1992). Mother's age and risk for physical abuse. Child Abuse and Neglect, 16, 709–718.

6 Stier, D., Leventhal, J., Berg, A., Johnson, L., & Mezger, J. (1993). Are children born to young mothers at increased risk of maltreatment? *Pediatrics, 91,* 462–468.

old (~ 9 percent) compared to children whose mothers were at least 22 years old (~ 4 percent).[7] Fourth, recent studies of intergenerational maltreatment have found that children whose adolescent mothers were neglected or abused may be at an increased risk of being maltreated compared to children whose adolescent mothers have no childhood abuse or neglect history.[8,9]

Finally, although relatively little is known about rate of child welfare services involvement among children whose parents were in foster care when they were born, an analysis of administrative data from the Illinois Department of Children and Family Services found that children born to youth in foster care are at high risk. Specifically, 39% of the children born to parents who were in foster care when their first child was born were the subject of at least one Child Protective Services (CPS) investigation, 17% had at least one indicated report, and 11% were placed in care at least once before their fifth birthday.[10]

Potential Benefits for Pregnant and Parenting Youth in care

Rigorous evaluations have demonstrated that home visiting programs can significantly reduce child abuse, improve parental functioning, and enhance child development.[11,12,13] Moreover, some studies suggest that these programs may be particularly effective with pregnant and parenting teens.[14,15,16,17] That said, efforts to include pregnant and parenting foster youth in

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7 Goerge, R., Harden, A., & Lee, B. (2008). Consequences of teen childbearing for child abuse, neglect, and foster care placement. In S. Hoffman, & R. Maynard (Eds.), *Kids having kids: Economic costs and social consequences of teen pregnancy* (pp. 257–288). Washington, DC: The Urban Institute Press.

8 Bartlett, J., & Easterbrooks, A. (2012). Links between physical abuse in childhood and child neglect among adolescent mothers. *Children and Youth Services Review, 34*, 2164–2169.

9 Putnam-Horstein, E., Cederbaum, J., King, B., & Needell, B. (2013). California's most vulnerable parents: When maltreated children have children. Agoura Hills, CA: Conrad Hilton Foundation.

10 Dworsky, A. (2015). Child welfare services involvement among the children of young parents in foster care. *Child Abuse and Neglect, 45*, 68-79.

11 Coalition for Evidence-Based Policy. (2009). *Early childhood home visitation program models: An objective summary of the evidence about which are effective*. Washington, DC: Coalition for Evidence Based Policy.

12 Geeraert, L., Van den Noorgate, W., Grietens, H., & Onghena, P. (2004). The effects of early prevention programs for families with young children at risk for physical child abuse and neglect: A meta-analysis. *Child Maltreatment, 9,* 277-291.

13 Sweet, M., and Appelbaum, M. (2004). Is home visiting an effective strategy? A metanalytic review of home visiting programs for families with young children. *Child Development, 75*, 1435 – 1456.

14 Barnet, B., Liu, J., DeVoe, M., Alperovitz-Bichell, K., & Duggan, A. (2007). Home visiting for adolescent mothers: effects on parenting, maternal life course, and primary care linkage. *Annals of Family Medicine, 5*, 224–232.

15 Jacobs, F., Easterbrooks, M., Brady, A., & Mistry, J. (2005). *Healthy Families of Massachusetts final evaluation report*. Medford, MA: Tufts University.

16 Olds, D., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K., Luckey, D., Henderson, C., Holmberg, J., Tutt, R., Stevenson, A., & Bondy, J. (2007). Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial. *Pediatrics, 120),* e832–e845.

17 Tonelli, M. (2006). Home visiting for the pregnant and parenting teen. *Journal of Pediatric and Adolescent Gynecology, 19,* 57–58.

intensive home-based interventions have been small in scale and reliable estimates of enrollment rates or impacts on parent and child outcomes have not been reported.[18]

Although pregnant and parenting foster youth have generally not been included in evaluations of evidence-based home visiting programs, there are a number of ways in which home visiting services could benefit pregnant and parenting youth in foster care. First, home visiting services can provide pregnant and parenting youth in foster care with critical knowledge about parenting and child development. Second, pregnant and parenting youth in foster care, who often lack a natural support system, can develop trusting relationships with home visitors. Third, delivering in-home services eliminates transportation and other access barriers that may make it difficult for youth in foster care to participate in the intervention and provides an opportunity to engage their foster parents or other caregivers. Finally, young parents who participate in a home visitation program can learn how to balance the demands of parenting with their own educational, employment, and emotional needs.

18 For example, a Nurse-Family Partnership (NFP) program implemented in Solano County, California expanded its target population to include pregnant foster youth and the pregnant partners of foster youth.

Home Visiting Pilot Overview

Healthy Families Illinois

Home visiting services were provided to pregnant and parenting youth in care by Healthy Families Illinois (HFI) programs. HFI programs are modeled after the evidence-based Healthy Families America (HFA) program. HFI home visitors, also known as 'family support workers' (FSW), provide voluntary, comprehensive services designed to support parents, improve parent child interaction, promote child health and development, and reduce the risk of child abuse and neglect.

Accredited HFI programs must meet the same standards as the HFA program and use the same level system for managing the intensity of the services provided to their clients (Table 1). Levels are based on client needs; clients with higher needs receive more frequent visits. Levels can also change over time as clients' needs for services change. At the start of the pilot, HFI agencies could select from six service levels. Five of those levels were for clients who were regularly engaged in home visiting services. The sixth level was for clients who were not regularly engaged. During the pilot, three new levels were added by HFA. One of those levels can be used for clients with special service needs. The other two can be used if circumstances prevented either the client or the home visitor from meeting regularly.

HFI accredited programs are typically required to enroll clients prenatally or before their child is three months old, and a majority of clients are enrolled within 2 weeks of giving birth. However, HFA granted a waiver that allowed HFI programs participating in the pilot to enroll pilot clients during pregnancy or before the child's first birthday. This extension of the enrollment period was critical because many youth in foster care either do not know or choose not to reveal that they are pregnant until quite late into their pregnancy.

Some HFI programs also provide doula services. Doulas are paraprofessionals who provide physical, emotional and informational support to mothers before, during and shortly after childbirth. Research has demonstrated the benefits of having a doula-supported birth including a reduction in the use of pain-relief medications (e.g., epidurals, oxytocin), a reduction in the rate of cesarean births, and more positive childbirth experiences.[19]

19 Hodnett, E., Gates, S., Hofmeyr, G., & Sakala, C. (2003). *Continuous support for women during childbirth*. Cochrane Database of Systematic Reviews. CD003766.

Table 1. HFA Service Intensity Levels

Level	Frequency of Home Visits	Additional Information
Level P (Prenatal)	At least once a month	Frequency determined by HV and supervisor based on severity and complexity of problems needing attention prior to birth and client's interest in participating
Level SS* (Special Services)	Determined by the situation, but can be more than weekly	Temporary level for families who experience needs that may require additional visits, services, or time
Level 1	Weekly	
Level 2	At least every other week	
Level 3	At least monthly	
Level 4	Quarterly	
Level X Creative Outreach	Length of time clients remain on creative outreach depends on the situation	Clients who have not been consistent with home visits or who cannot be located can be placed on CO for up 3 months
Level TO* (Temporary Out of Area)	Length of time clients remain on TO depends on the situation	For clients who temporarily leave the area for up to 3 months and are expected to return
Level TR* (Temporary Re-Assignment)	Length of time clients remain on TR depends on the situation	Available when staff leave results in services being interrupted but families should not remain on TR longer than 3 months.

*New levels added by HFA during the course of the pilot.

Goals of the Home Visiting Pilot Program

The Home Visiting-Child Welfare Sub-Committee identified several goals for the pilot:

- Provide pregnant and parenting youth in care with access to voluntary home visiting services in their communities;
- Promote nurturing parent-child relationships and healthy child development;
- Enhance family functioning by reducing risk and building protective factors;
- Break the intergenerational cycle of abuse, neglect, and trauma;
- Increase coordination between the child welfare system and home visiting programs;
- Create a model for delivering high quality home visiting services that can be replicated with DCFS-involved families throughout the state.

Funding

The home visiting services provided to pilot participants and the infant mental health consultation provided to home visitors were supported with Maternal, Infant and Early Childhood Home Visiting (MIECHV) funding as well as funding from the Department of Human Services (DHS) and the Illinois State Board of Education (ISBE). The Chapin Hall evaluation of the Home Visiting Pilot was funded by DCFS.

Healthy Families Illinois Programs

Nine HFI programs participated in the pilot project: Advocate Illinois Masonic Medical Center, Children's Home + Aid, Children's Home Association, Easter Seals Rockford, Family Focus Englewood, Healthy Families Chicago, Sinnissippi Centers, Stephenson County Health Department, and Teen Parent Connections. The three Cook County agencies serve clients in certain Chicago neighborhoods. The other programs serve clients in DuPage, DeKalb, McLean, Peoria, Stephenson, Whiteside and Winnebago Counties. Five of the nine home visiting programs offered doula services.

Table 2. Counties Served by Home Visiting Programs

Home Visiting Program	Counties Served
Advocate Illinois Masonic Medical Center	Cook*
Children's Home + Aid	McLean & DeKalb
Children's Home Association	Peoria
Easter Seals Rockford	Winnebago
Family Focus Englewood	Cook*
Healthy Families Chicago	Cook*
Sinnissippi Centers	Whiteside
Stephenson County Health Department	Stephenson
Teen Parent Connections	DuPage

*Select Chicago neighborhoods only

Eligibility

Youth in DCFS care were eligible for the pilot if they were pregnant or the parent of a child who was not yet one-year old *and* were living in a catchment area served by one of nine HFI programs. Eligible youth were identified by the Teen Parenting Services Network (TPSN). TPSN is the lead agency of a network of service providers that offer case management, placement, and parenting services to pregnant/parenting youth in care.

Eligibility for home visiting services did not end when a youth aged out or otherwise exited DCFS care. Rather, pilot clients remained eligible for home visiting services until their child's third birthday (or fifth birthday for some programs). If the child of a parent enrolled in the pilot was removed from the parent's care and taken into DCFS custody, the parent remained eligible for home visiting services as long as the child's permanency goal was return home.

Concerns were raised early on about the potential for duplication of services because some youth in care receive parenting services from the pregnant and parenting providers with which DCFS contracts to complete the new birth assessment (NBA). The NBA is an assessment administered to all youth in care who give birth to or father a child. The assessment covers four domains (i.e., pregnancy, birth, and follow-up care; parent-child interactions; safety and risk factors; and interventions/information). It also includes the Adult-Adolescent Parenting Inventory (AAPI), a 40-item measure of parenting attitudes and child rearing practices is used to determine whether parents are at low, medium, or high risk for child abuse or neglect in each of five domains (i.e., parent/child role reversal, parental expectations of children, use of corporal punishment, children's power and independence, and parental empathy towards children's needs).[20] NBA assessors can provide services for up to a year. Services typically begin prenatally and end several months after a baby's birth. If a youth who was already receiving parenting services was referred to the pilot, she was placed on the "eligible" list until those parenting services ended. As long as her child was not yet a year old, she could enroll in the pilot at that point. However, none of the youth who were placed on the "eligible" list ever enrolled this way.

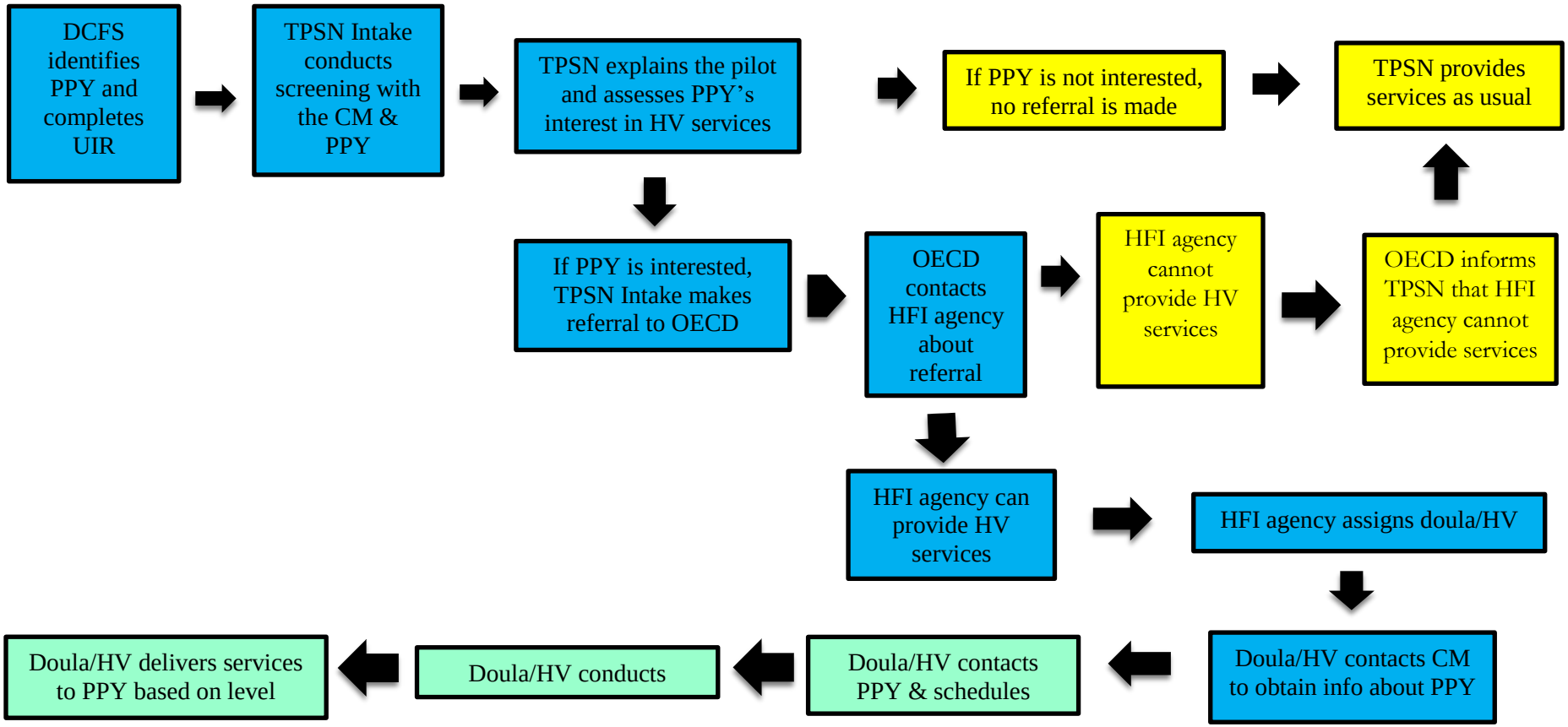
Referral, Outreach and Enrollment Process

In a few cases, HFI programs learned about potential pilot client through their regular coordinated intake processes or a potential pilot client reached out directly to the HFI program. In those instances, the home visiting supervisor contacted the pilot project manager, who then reached out to TPSN to confirm the potential pilot client's eligibility.

The HFI program assigned the pilot client to a doula (if the client was pregnant) or a home visitor (if the client was parenting or if the program had no doulas). The doula or home visitor engaged in outreach to enroll the client in the pilot. Once a client accepted services, the home visitor or doula enrolled the client at Level P, if the client was pregnant, or Level 1, if the client was parenting, and began making home visits (See Figure 1). Because HFI is a voluntary program, youth could discontinue their participation at any time.

[20] Bavolek, S., & Keene, R. (2001). *Adult-Adolescent Parenting Inventory AAPI-2: Administration and development handbook.* Park City, UT: Family Development Resources, Inc

Figure 1. Home Visiting Pilot Case Flow



*PPY = Pregnant or parenting youth

**CM = Case manager

***HV = Home visitor or home visiting

Training and Support

Prior to the start of the pilot, home visitors, doulas and supervisors whose HFI programs were participating in the pilot were invited to participate in a cross-training with child welfare workers. The cross trainings were held in three sites across the state. Most of the participants were home visitors or home visiting supervisors. Relatively few child welfare workers attended.

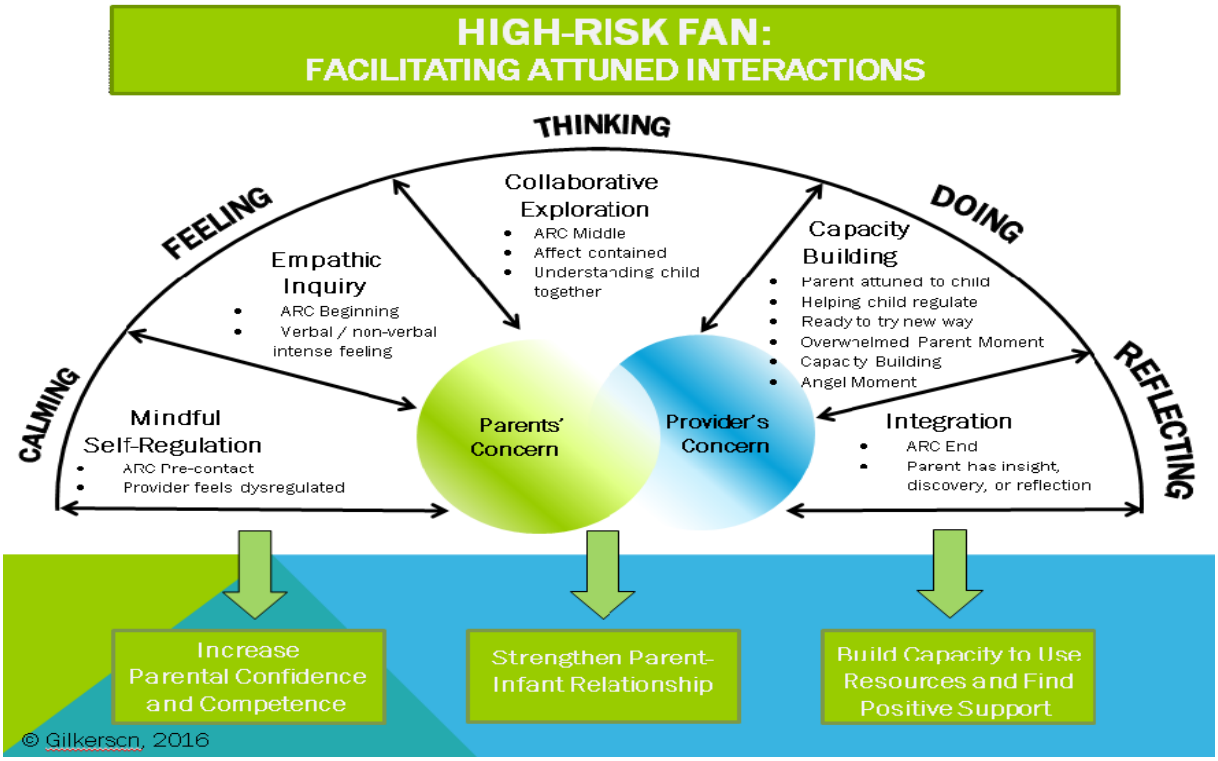
The training was designed and delivered by members of the Child Welfare Subcommittee of the Home Visiting Taskforce from TPSN, Erickson Institute and the Ounce of Prevention. Its purpose was to provide home visitors with information about the children welfare system and TPSN, to provide child welfare workers with information about home visiting, and to provide both groups with information about the pilot.

To reduce the potential for duplication of services with the pregnant and parenting youth service providers with which DCFS contracts to complete the NBA (described above), home visitors were trained to administer the NBA as part of the cross-training. Soon after the pilot began, home visitors began voicing concerns that administering the NBA felt at odds with their approach which is to follow the client's lead with respect to what topics to discuss. In response to this feedback, the Child Welfare Subcommittee of the Home Visiting Taskforce agreed that home visitors should not administer the NBA.

Other supports available to home visitors and doulas included reflective supervision with their supervisors, infant mental health consultation, and Facilitating Attuned Interactions (FAN) training. Infant mental health consultants are professionals who help home visitors, doulas and their supervisors reflect on their work with families and process issues that arise in the course of that work. The FAN is an approach developed by the Erikson Institute's Fussy Baby Network to enhance the skills of home visitors who work with the families of young children (Figure 4).[21] The home visitor determines which of five core processes to use based on a parent's cues.

21 Gilkerson, L., Hofherr, J., Heffron, M., Sims, J., Jalowiec, B., Bromberg, S., & Paul, J. (2012). Implementing the Fussy Baby Network Approach. *Zero to Three, 33,* 59-65.

Figure 2. High-risk FAN Home Visiting Approach



Communication

Several months into the pilot, two changes were made to encourage more cross-system communication between HFI programs and child welfare caseworkers. First, the pilot project manager began sending emails to the HFI program supervisor of each pilot client's home visitor or doula and to the pilot client's child welfare caseworker to inform the caseworker that the client was receiving home visiting services as part of the pilot and provide both with each other's contact information. Second, a TPSN staff member began sending emails to the child welfare caseworkers of each new the pilot client, with the home visitor or doula copied, to arrange a Child and Family Team meeting at which the home visitor could be present.

Logic Model

Chapin Hall worked with the Child Welfare Subcommittee of the Home Visiting Taskforce to develop a logic model for the pilot (Figure 3). The short- and long-term outcomes are based on the indicators recommended by the Pew Charitable Trusts' Home Visiting Data for Performance Initiative.[22]

[22] The Pew Charitable Trusts. (2015). *Using data to measure home visiting performance*. Washington, DC: The Pew Charitable Trusts.

Figure 3. Pilot Logic Model

Objectives	*Inputs*	*Activities*	*Outputs*	*Short-term Outcomes*	*Long-term Outcomes*
• Provide home visiting services to pregnant and parenting youth in care using a modified version of the HFA model • Promote nurturing parent-child relationships • Promote healthy child development • Enhance family functioning by reducing risk and building protective factors • Break intergenerational cycle of abuse, neglect, and trauma • Increase coordination between the child welfare and home visiting systems in Illinois	• HFI Agencies • HFI Home visitors • Cross training provided by UCAN or Ounce of Prevention • Reflective supervision • Clinical and Infant Mental Health consultation • Coordination and sharing of information among HFI programs, DCFS and TPSN • DHS and MIECHV funding • HFI programs with doulas • Coordinated referral through Governor's Office of Early Childhood Development	***TPSN/DCFS will:*** • Refer eligible youth (i.e., pregnant females and parents with a child under age 1) • Encourage voluntary participation in HV services • Coordinate and facilitate Child and Family Team meetings at least quarterly • Ensure basic needs of mother and child are met ***Home visitors and TPSN will:*** • Create a trusting relationship with pregnant/parenting youth • Complete the New Birth Assessment • Develop goal plans • Encourage prenatal care receipt and compliance with medical advice • Make appropriate referrals and facilitate access to needed services and community resources • Educate parents about child development, child safety (including safe sleeping) and prevention of child injuries • Provide information about childcare options, including childcare assistance and family planning • Encourage co-parent involvement ***Home visitors will:*** • Engage and retain parents in home visiting program • Provide breast feeding education and support • Assess parent-child interactions • Promote secure attachment and positive discipline techniques • Teach activities to promote child development • Screen for depression, domestic violence, and substance abuse • Promote healthy and discourage risky behaviors • Teach critical thinking, problem solving, and stress management skills • Conduct developmental screenings • Monitor child well visits and immunizations Encourage connection to a medical home	• Pregnant and parenting youth receive home visiting services • Home visitors visit pregnant and parenting youth at a frequency consistent with HFA standards • Child and Family Team meetings occur at least quarterly with the parent's assigned home visitor present • Home visitors and TPSN staff have participated in cross-training • Representatives from TPSN, DCFS and HFI programs attend quarterly meetings to discuss opportunities and challenges and provide feedback about the pilot to the Governor's Office	***Birth related outcomes*** • Mothers receive postpartum health care within two months of giving birth (if they were enrolled before giving birth) • Mothers breastfeed for at least three months after giving birth (if they were enrolled before giving birth) ***Parent outcomes*** • Parents quit smoking/using tobacco (if they smoked/used tobacco prior to enrollment) • Mothers are screened for maternal depression and referred for treatment if appropriate • Parents demonstrate more positive parenting and child rearing attitudes ***Child Outcomes*** • Children receive well-child checks as recommended by the AAP • Children receive a developmental screening • Children are achieving general developmental milestones at the expected ages • Children with developmental delays are referred for services **System Outcomes** • Home visitors and TPSN staff communicate regularly about shared clients	***Parent outcomes*** • Mothers do not experience a subsequent pregnancy prior to emancipation • Parents without a high school credential earn their high school diploma or GED • Parents with a high school credential enroll in postsecondary education or training program or become employed • Parents have health insurance coverage and are connected to a medical home following emancipation • Parents demonstrate more positive parenting and child rearing attitudes ***Child Outcomes*** • Children are not the focus of a child maltreatment investigation • Children are not the focus of an indicated child maltreatment report • Children are not placed in care • Children are achieving general developmental milestones at the expected ages • Children are enrolled in an accredited early learning program or licensed day care by age 3 • Children have health insurance coverage and are connected to a medical home following parent's emancipation **System Outcomes** • Home visiting programs have the specialized training and support needed to serve pregnant and parenting youth in care • Data are being used by TPSN, DCFS and the HFI programs to improve practice

Continuous Quality Improvement

Immediately after the pilot began, a continuous quality improvement (CQI) process was established to monitor the pilot's implementation, identify problems and take corrective action. Central to this CQI process was the pilot core team's weekly conference call. That team included the project manager from the Governor's Office of Early Childhood Development (GOECD), TPSN staff, and the Chapin Hall evaluators. These calls served two main purposes.

The first purpose was information sharing. During the calls, the core team discussed potential referrals and reviewed the status of referred, open, and transferred cases. These discussions were informed by data being collected from home visitors and doulas about each completed or missed home visit, by information the project manager had received about pilot clients from home visitors or doulas, and updates TPSN staff provided about placement changes, runaway events, or other child welfare case developments that might affect service delivery. When appropriate, this information was shared with the supervisor of the relevant HFI program.

The second purpose was troubleshooting. When the evaluation team reported that a pilot client was consistently missing visits or no visits were being reported, the project manager would follow up with the HFI program's supervisor. Likewise, when the project manager reported that residential care staff were making it difficult for home visitors and doulas to provide services or pilot clients were experiencing problems, TPSN staff would intervene.

These weekly conference calls proved critical to the pilot's success. Although they were only expected to be a temporary measure while the pilot got off the ground, they continued for more than two years. It was only when enrollment had ended that the frequency of the calls was reduced from every week to twice a month.

In addition to these weekly conference calls, the core team engaged in four other CQI activities. First, the core team facilitated two all-day meetings hosted by Children's Home + Aid. The meetings provided home visitors, doulas and supervisors an opportunity to share their pilot experiences---both positive and negative--with one another and with the core team. During the second meeting, TPSN gave a presentation on transitioning planning for youth aging out of care and suggested ways in which home visitors could support youth during their transition. The Chapin Hall evaluation team also shared preliminary data from the evaluation.

Second, TPSN and the project manager facilitated a meeting for the residential care and TLP providers with whom some of the pilot clients were placed. During that meeting, the TLP and residential care providers learned more about the pilot and about home visiting and doula services. Third, the core team created a "tip sheet" (See Appendices A and B) for home visitors, doulas, and supervisors that provided information about the evaluation and whom to call with different types of questions (e.g., general questions about the pilot, questions about specific pilot clients, or questions about the evaluation).

Finally, the Child Welfare Subcommittee of the Home Visiting Task Force, which included the core team, met monthly for the first four months of the pilot and then approximately every other month thereafter. During these meetings, the project manager provided an update on the number of referrals that had been received as well as the number cases that had been opened and closed. The meetings were an opportunity to discuss some of the implementation challenges that the core team had observed, explore strategies to address those challenges, and plan for expanding the initiative beyond the pilot sites. Additionally, on several occasions, the Chapin Hall team shared preliminary evaluation results.

Method

Data Sources

The evaluation of the pilot used three types of data: program data collected from home visitors and doulas; qualitative interview data collected from home visitors, doulas, supervisors and parents; and, child welfare administrative data. Data collection began on November 1, 2016 and continued through March 31, 2019.

Home Visiting Program Data

Chapin Hall developed a web-based data collection tool for collecting pilot data.[23] Each HFI program was provided with a unique link which its doulas and home visitors used to enter information about each visit with a pilot client. Table 3 lists some of the information that was collected. Chapin Hall provided training on how to use the data collection tool and ongoing data entry support.

Table 3. Information Captured by Data Collection Tool

Visit date	Prenatal or postpartum visits
Visit missed or completed	Well-child visits/immunizations
Reason for missed visit	Breastfeeding status
HFI level	Activities engaged in during visit
Pregnancy status at enrollment	Screenings or assessments administered
Due date if pregnant	Referrals made
Birth outcome	Interactions with child welfare system
Child date of birth	Subsequent pregnancy
Doula assistance at birth	Presence of child's father during visit

HFI programs use a number of different screening and assessments tools, and different tools are used by different programs. Table 4 provides information about the screenings and assessments tools whose use was tracked as part of the evaluation.

23 The tool uses REDCap (Research Electronic Data Capture), a secure, HIPPA-compliant application maintained by the University of Chicago. The University of Chicago's REDCap project is hosted and managed by the Center for Research Informatics and funded by the Biological Sciences Division and by the Institute for Translational Medicine, CTSA grant number UL1 TR000430 from the National Institutes of Health.

Table 4. Screening and Assessment Tools

Screening or Assessment Tool	Description
Ages and Stages Questionnaire (ASQ)[24]	Screens infants and young children for developmental delays from birth to age 5
Ages and Stages Questionnaire Social-Emotional (ASQ-SE)[25]	Assesses the social and emotional development of children from birth to age 5
Edinburgh Postnatal Depression Scale[26]	Screens for maternal postnatal depression
Kempe Family Stress Inventory[27]	Assesses risk for parenting difficulties based upon responses to a psychosocial interview
Parenting Stress Inventory[28]	Screens for stress in the parent-child relationship, dysfunctional parenting and child adjustment problems
Maternal Efficacy Questionnaire[29]	Assesses perceived knowledge of appropriate child-rearing behaviors and confidence in one's ability to perform parenting tasks
Protective Factors Survey[30]	Measures protective factors in 5 areas: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development
Knowledge of Infant Development Inventory (KIDI)[31]	Assesses knowledge of parenting practices, developmental processes, and infant milestones
Family Resource Scale[32]	Assesses the adequacy of a family's resources

[24] Squires, J., & Bricker, D. (2009). Ages & Stages Questionnaires (ASQ-3): A *parent-completed child monitoring system. 3rd ed. Baltimore: MD: Brookes* (2009).
[25] Squires, J., Bricker, D., & Twombly, L. (2002). *Ages and stages questionnaires: Social-emotional.* Baltimore: Brookes.
[26] Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry*, *150*(6), 782-786.
[27] Korfmacher, J. (2000). The Kempe family stress inventory: A review. *Child Abuse & Neglect*, *24*(1), 129-140.
[28] Abidin, R. R., & Abidin, R. R. (1990). *Parenting Stress Index (PSI)*. Charlottesville, VA: Pediatric Psychology Press.
[29] Teti, D., & Gelfand, D. (1991). Behavioral competence among mothers of infants in the first year: The mediational role of maternal self-efficacy. *Child Development, 62*, 918–929.
[30] Counts, J., Buffington, E., Chang-Rios, K., Rasmussen, H., & Preacher, K. (2010). The development and validation of the protective factors survey: A self-report measure of protective factors against child maltreatment. *Child Abuse & Neglect, 34*(10), 762-772.
[31] Macphee, D. (1981). *Knowledge of Infant Development Inventory: Manual*. Chapel Hill, NC: Department of Psychology, University of North Carolina.
[32] Dunst, C. J., & Leet, H. E. (1985). Family resource scale. Morganton, NC: Western Carolina Center.

Interview Data

Semi-structured interviews were conducted with home visitors, doulas, supervisors and parenting youth. Parenting youth were interviewed approximately three months after they enrolled in the pilot or three months after giving birth if they enrolled prenatally. Some of the parenting youth were interviewed a second time six months after the first interview. Fourteen of the 32 home visitors, 3 of the 9 doulas, 3 of the 9 supervisors, and 29 parenting youth were interviewed. Eleven of the parenting youth were interviewed twice.

Administrative Data

DCFS administrative data were used to examine the demographic characteristics and placement histories of the pregnant and parenting youth who participated in the pilot and to their children's child welfare services involvement.

Participation in the Evaluation

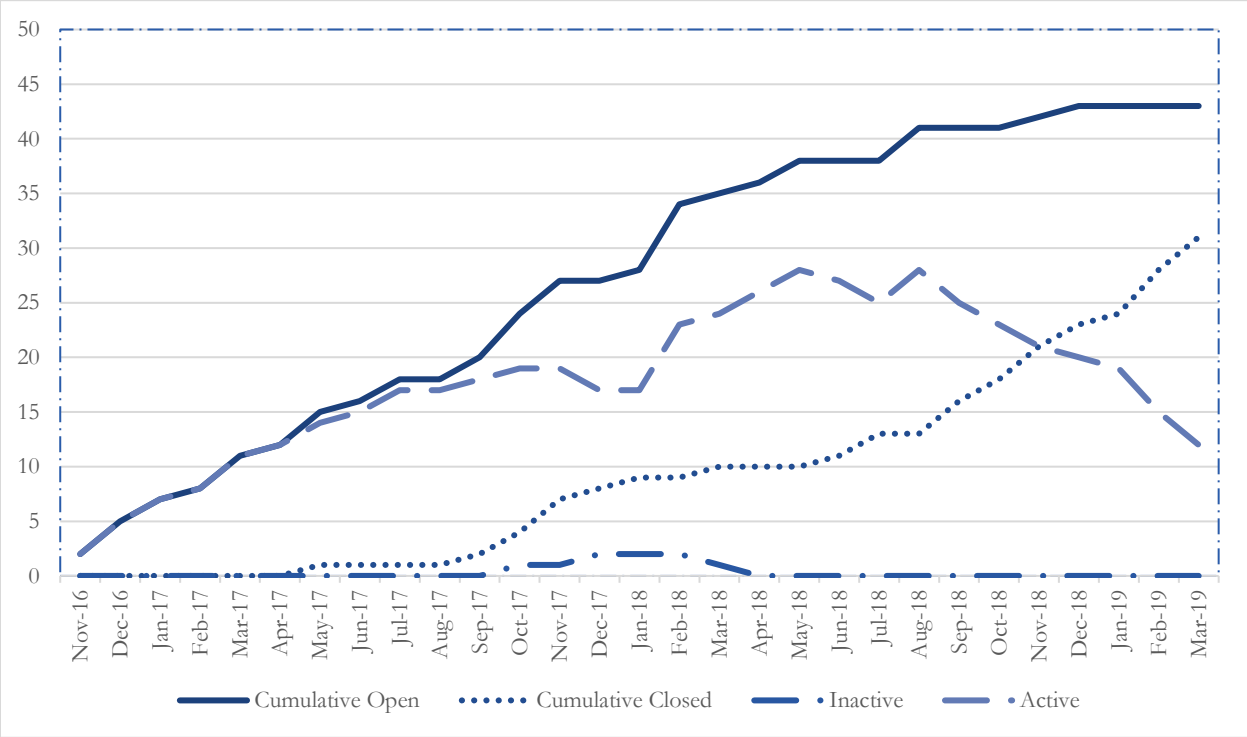
During the engagement process, the home visitor or doula informed pilot clients about the evaluation and obtained their permission to share data about their visits with the evaluation team. Pilot clients were not required to participate in the evaluation in order to receive home visiting services. Informed consent was obtained from all the home visitors, doulas, supervisors and parenting youth who were interviewed.

Pilot Referrals and Enrollment

Altogether, 61 pregnant or parenting youth were referred for home visiting services. Of those, 43 enrolled in the pilot between November 2016 and December 2018. This exceeded the initial goal of enrolling 30 pregnant or parenting youth. December 2018 was the last month in which new pilot clients could be enrolled, and only 12 pilot clients were still receiving services at the end of evaluation period.

Most of the 31 pilot clients who were no longer receiving services at the end of the evaluation period had moved outside the catchment areas of the nine HFI programs participating in the pilot (n = 13) or had failed to respond to repeated outreach efforts by their HFI program (n = 13). The remaining pilot clients decided that they no longer needed services, were too busy with school or work to participate, preferred to participate in services provided by a non-pilot program, or were the parent of child who achieved permanency through subsidized guardianship. Figure 4 shows how the number of clients enrolled in the pilot changed over time.

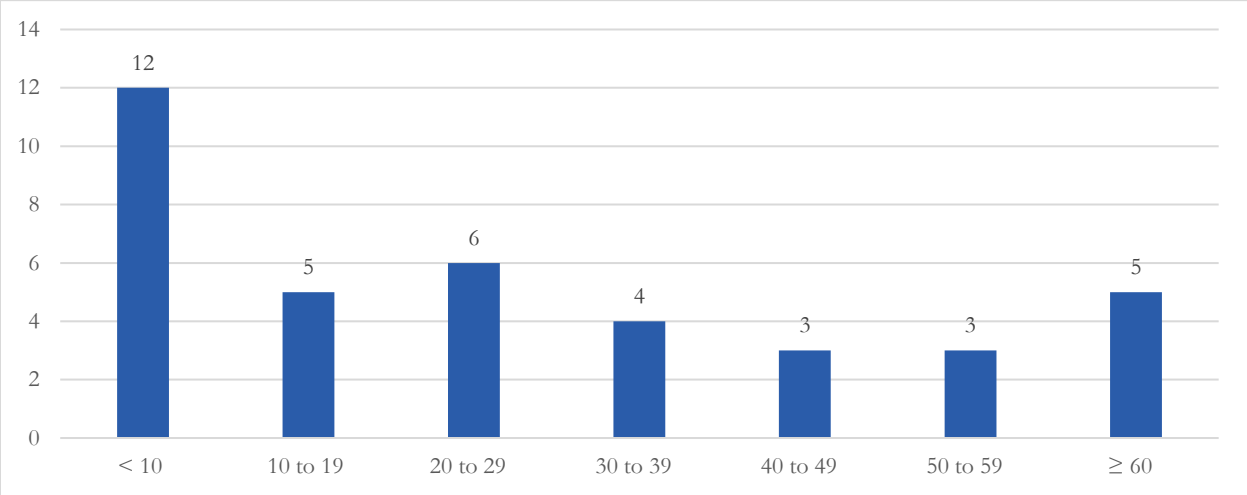
Figure 4. Number and Status of Pilot Clients Over Time



There were a number of reasons pregnant and parenting youth who were referred for home visiting services did not enroll in the pilot. Seven did not respond to outreach efforts, five refused services, four moved outside of the catchment areas served by the HFI programs participating in the pilot, one could not be served because the HFI program was at capacity, and one enrolled in a different home visiting program.

Figure 5 shows the number of days from referral to enrollment for the 38 pregnant and parenting youth who enrolled in the pilot after being referred by TPSN. The average time between referral and enrollment was 34 days.

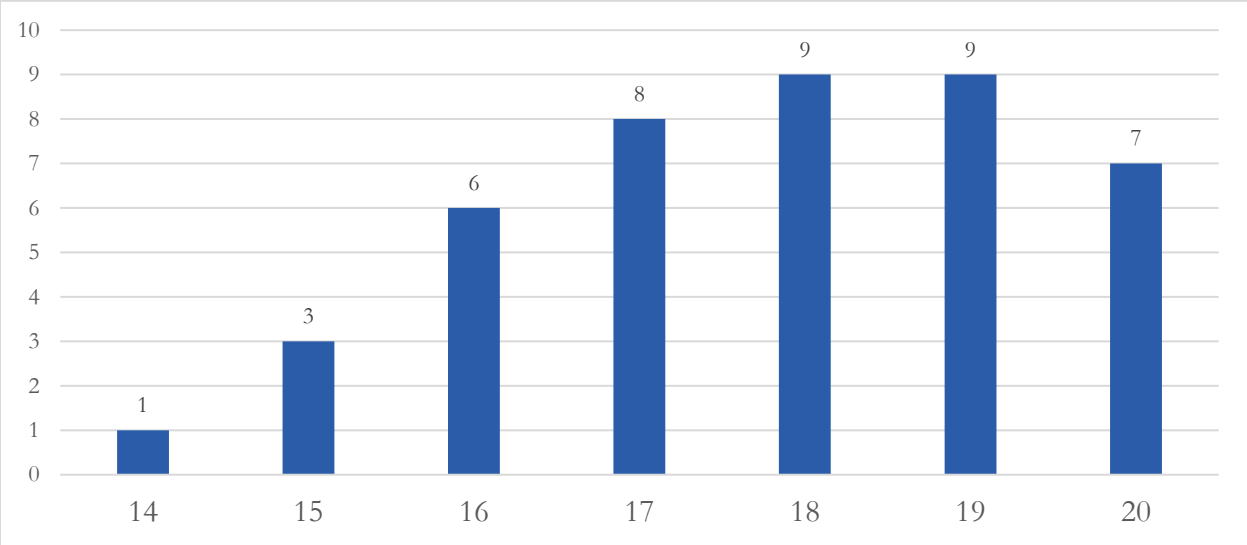
Figure 5. Days from Referral to Pilot Enrollment



Pilot Clients Characteristics

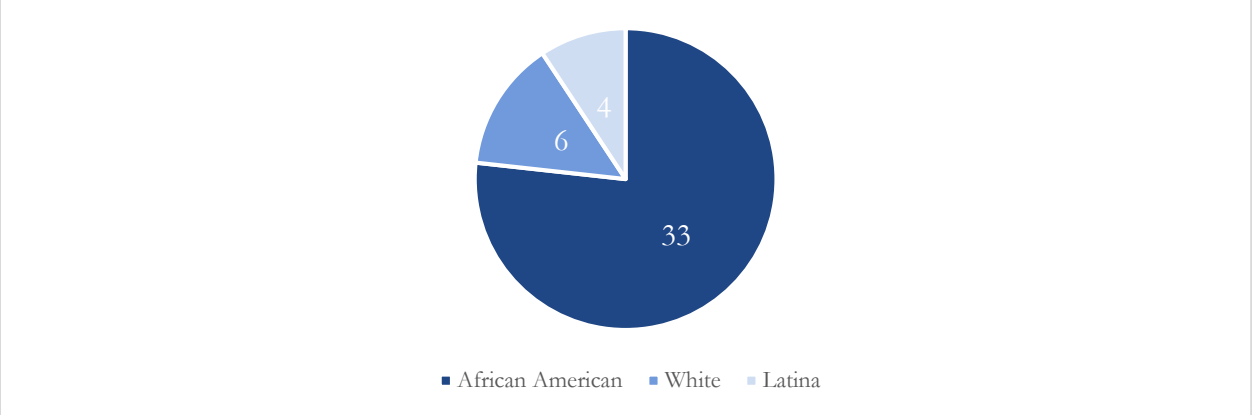
Although young men who were fathers or fathers-to-be were eligible for the pilot, only young women enrolled. The age of pilot clients at enrollment ranged from 14 to 20 years old (Figure 6). The average age at enrollment was 18.3 years old.

Figure 6. Age in Years at Enrollment



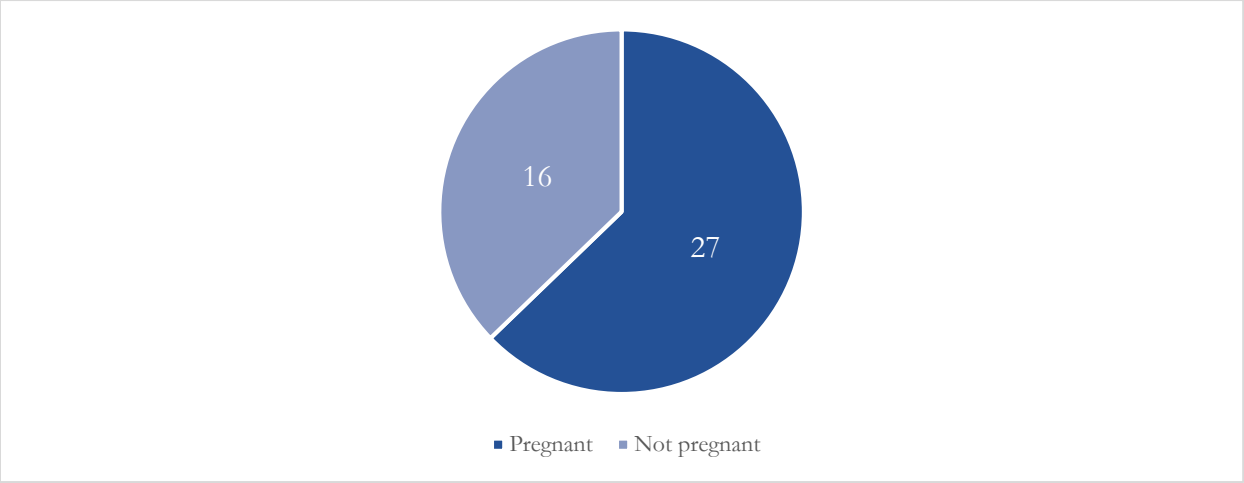
Just over three quarters are African American (Figure 7). The other third are white or Latina.

Figure 7. Race/Ethnicity



Twenty-seven of the pilot clients were pregnant at enrollment and 16 were the parent of a child who was not yet one year old (Figure 8). Two of the pregnant clients already had at least one child. Twenty-five of the 27 pilot clients who were pregnant at enrollment gave birth while they were enrolled. The other two were still pregnant when the evaluation ended.

Figure 8. Pregnancy Status at Enrollment



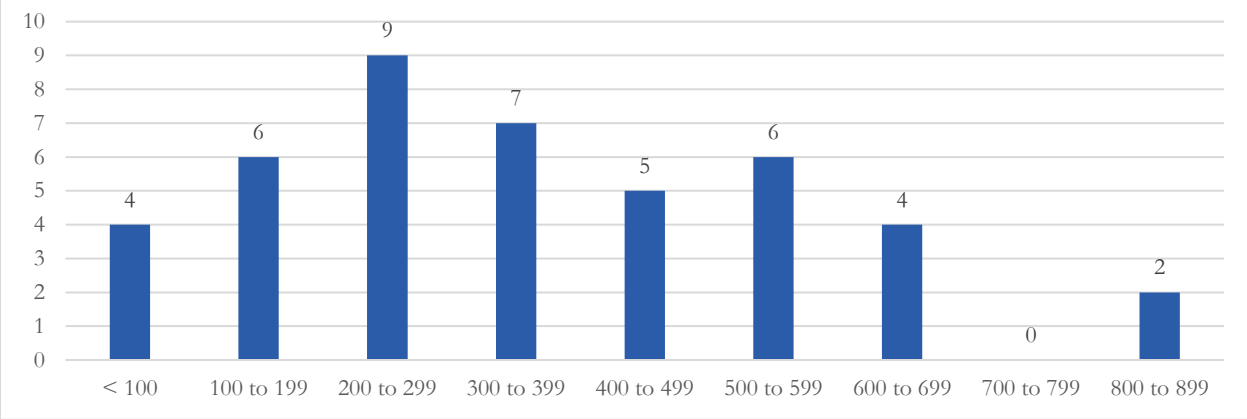
Although 25 of the 27 pilot clients who were pregnant at enrollment gave birth while they were enrolled, home visitors and doulas only reported 18 births. In some cases, pilot clients missed all of their visits after giving birth despite repeated attempts by their home visitor or doula to meet with them. At least 14 of the 18 pilot clients for whom a birth was reported had a postpartum visit and at least 12 breastfed for some period of time. None of the 18 pilot clients for whom we have data gave birth preterm or to a low birthweight baby.

Thirteen of the pilot clients experienced a pregnancy after their enrollment in the pilot. Nine of those pregnancies were reported by a home visitor or doula. The core team learned about the other four pregnancies from TPSN during their weekly or biweekly conference calls.

Pilot Experiences

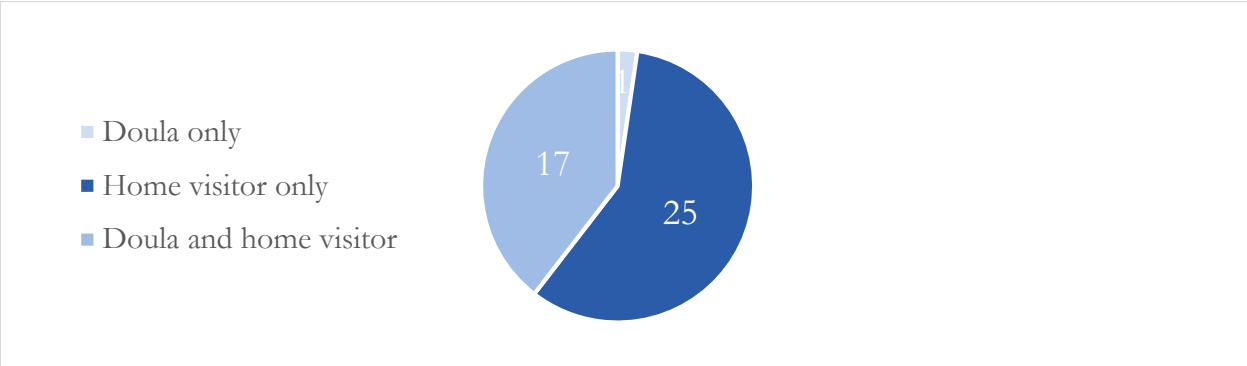
Figure 9 shows the number days clients were enrolled in the pilot as of March 31, 2019. On average, clients were enrolled in the pilot for 362 days or just shy of a year.

Figure 9. Total Days Enrolled in Pilot



Twenty-five pilot clients were assigned a home visitor only, one pilot client was assigned a doula only and 16 pilot clients were assigned both a doula and a home visitor (Figure 10).[33] Eleven of the pilot clients who were assigned a doula had a doula-supported birth. The other six pilot clients who were assigned a doula gave birth without doula support. One had discontinued doula services prior to giving birth and four chose not to notify their doulas when their labor began. One pilot client did not have a doula-supported birth because residential care staff did not notify her doula when she went into labor.

Figure 10. Home Visitor and Doula Assignments



[33] These figures include one client who was parenting when she enrolled in the pilot. She received doula services during a subsequent pregnancy.

Figure 11 shows the total number of completed and missed visits reported by home visitors and doulas each month between November 2016, when the pilot began, and March 2019, when data collection ended. Of the 1,468 visits that were reported during those 29 months, 972 or 66 percent were completed.

Figure 11. Completed and Missed Visits by Month

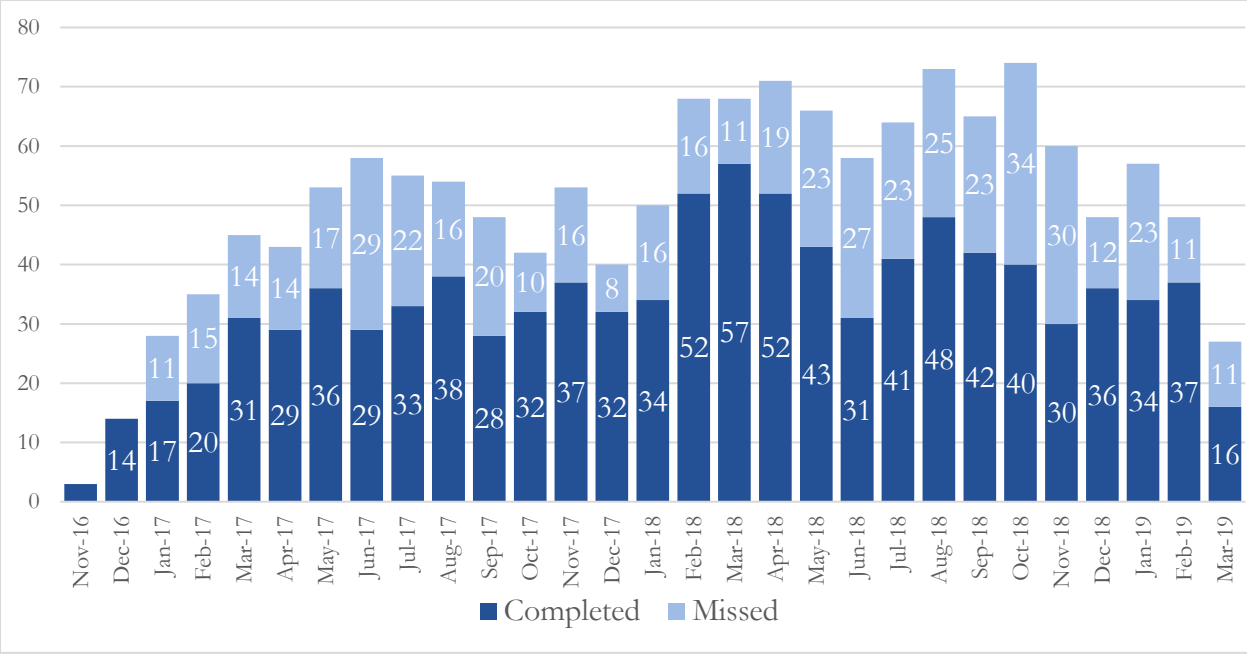


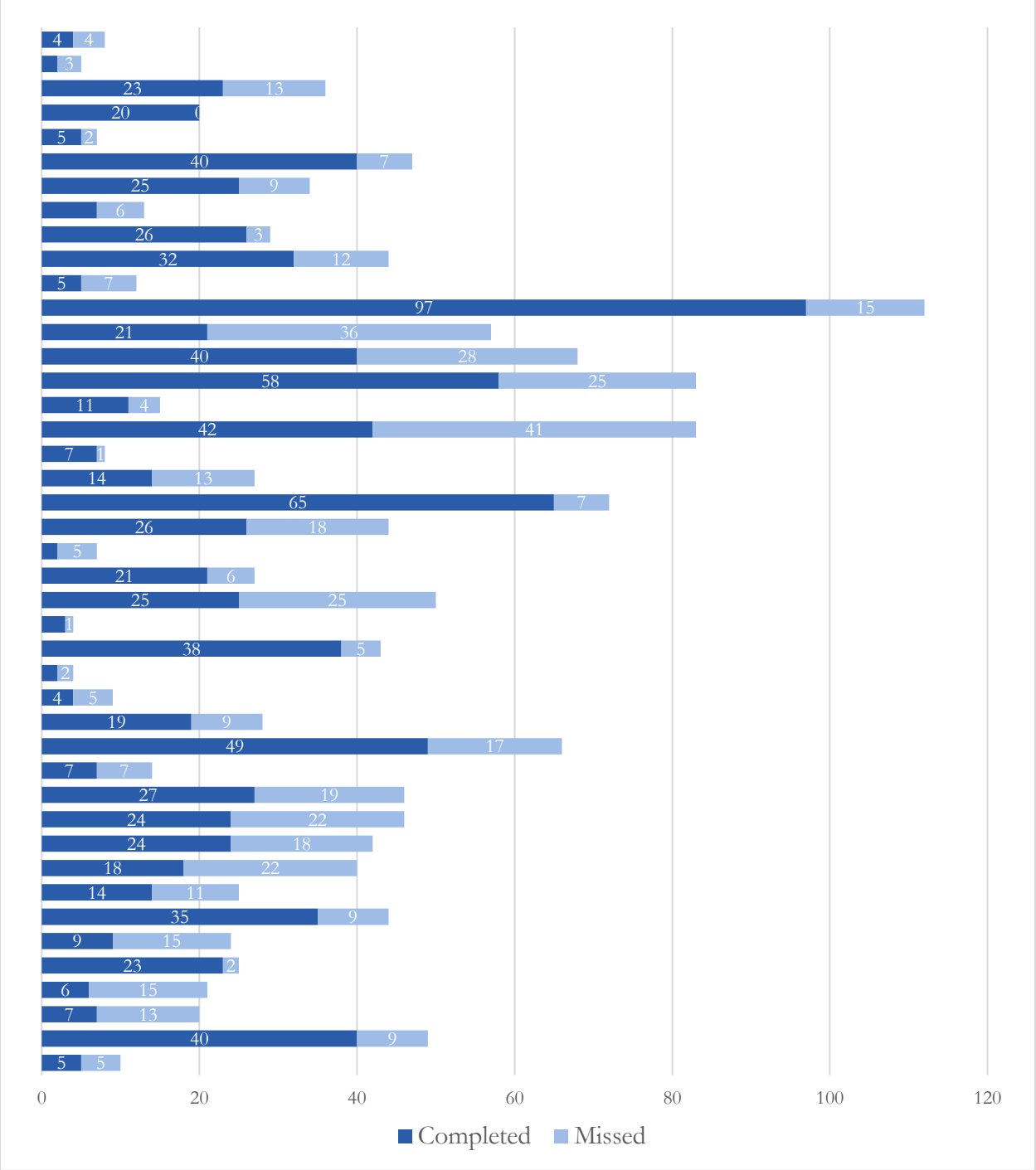
Table 5 shows the reasons visits with home visitors and doulas were missed. The two most common reasons were the pilot client not being home (30%) and the home visitor or doula not being able to contact the pilot client (22%).

Table 5. Reason for Missed Visits

	Frequency	Percentage
Parent or child illness	29	6%
Conflict with other parent or child appointment	69	14%
Client not home	149	30%
Unable to contact client	110	22%
Client refused visit	58	12%
Home visitor cancelled	34	7%
Other	36	7%
Missing	11	2%

Figure 12 shows the total number of completed and missed visits reported by home visitors and doulas for each pilot client between November 2016, when the pilot began, and March 2019, when data collection ended. The number of completed visits ranged from 2 to 97 and the percentage of visits that were completed ranged from 29 percent to 100 percent.

Figure 12. Completed and Missed Visits by Pilot Client



Home visitors and doulas engaged in a wide variety of activities with their pilot clients. Figure 13 shows the number of visits during which home visitors and doulas engaged in different types of activities. The four activities home visitors and doulas engaged in most often were observing clients interacting with their babies, promoting healthy behaviors, promoting secure attachment and providing child development education.

Figure 13. Frequency of Activities as Measured by the Number of Visits

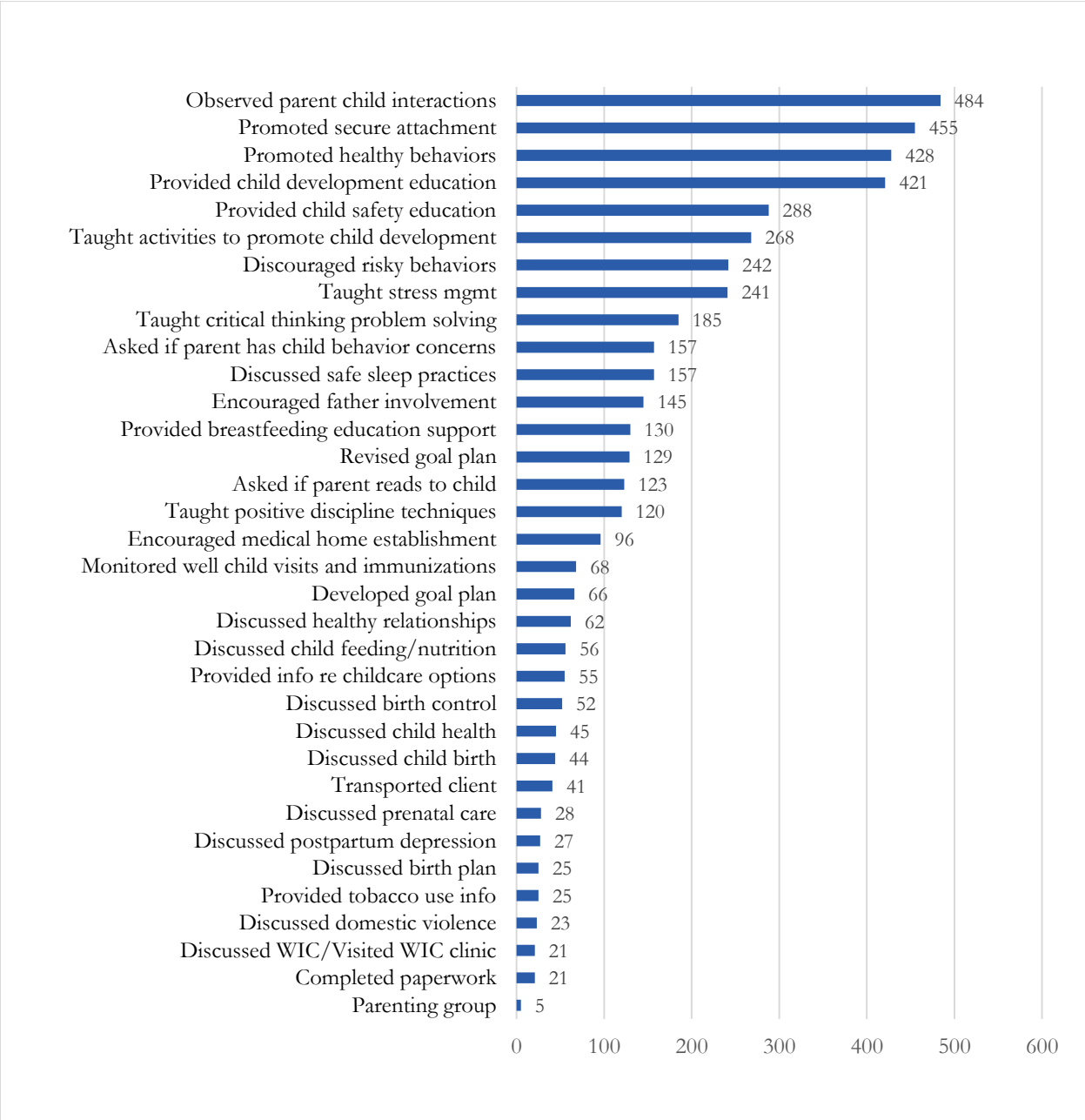
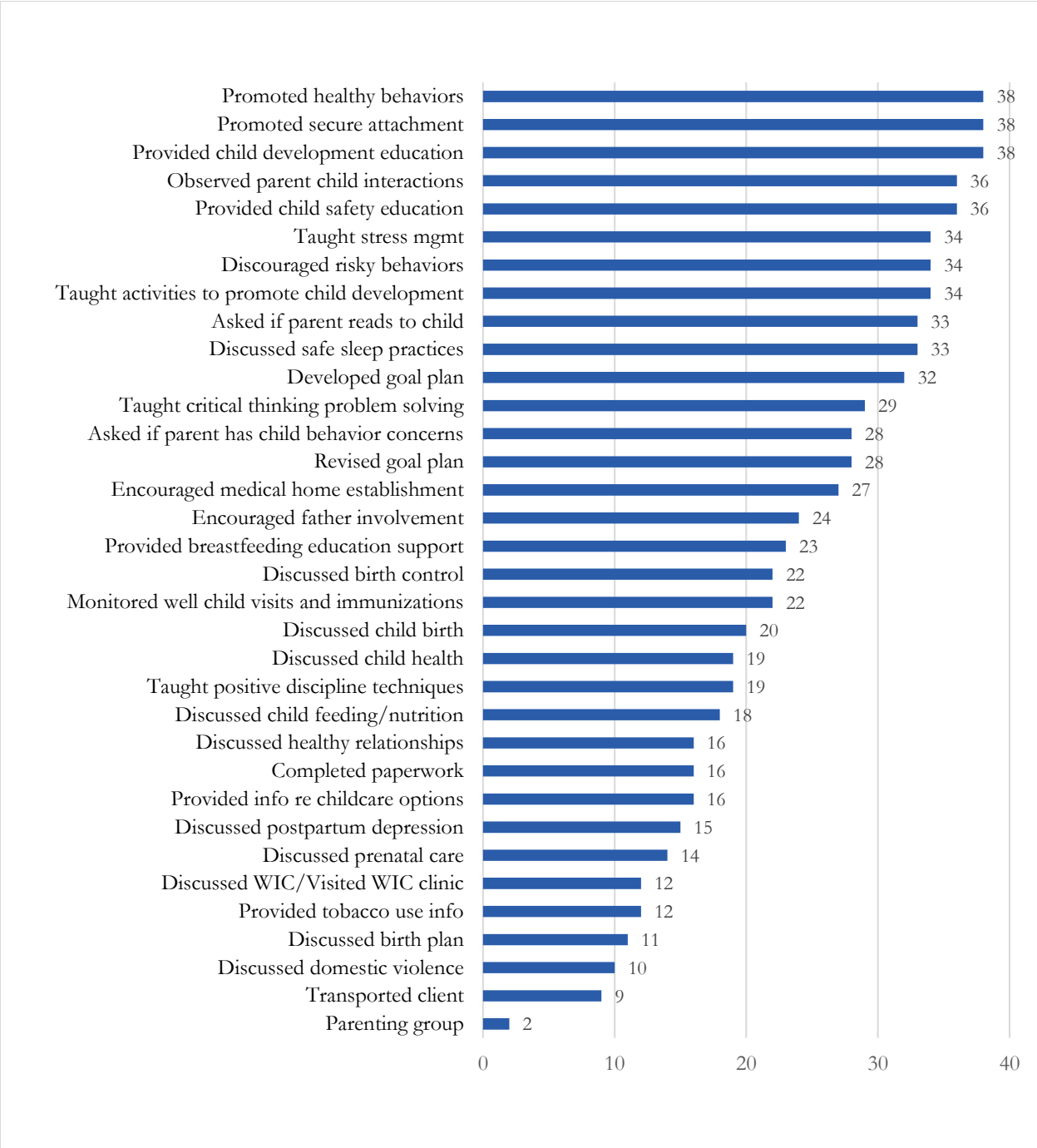


Figure 14 shows the number of pilot clients with whom home visitors or doulas engaged in different types of activities at least once. Home visitors and doulas engaged in five activities with more than 35 pilot clients: promoting healthy behaviors, promoting secure attachment, providing child development education, observing parent-child interactions and providing child safety education.

Figure 14. Frequency of Activities as Measured by the Number of Pilot Clients



Home visitors and doulas completed 218 assessments during the course of the pilot. Figure 16 shows the number of visits during which different assessments were completed. By far, the two most commonly administered assessments were the Edinburgh Postnatal Depression Scale and the Ages and Stages Questionnaire. These are the only two assessments that are used by all, or nearly all, of the HFI programs.

Figure 15. Frequency of Assessments as Measured by the Number of Visits

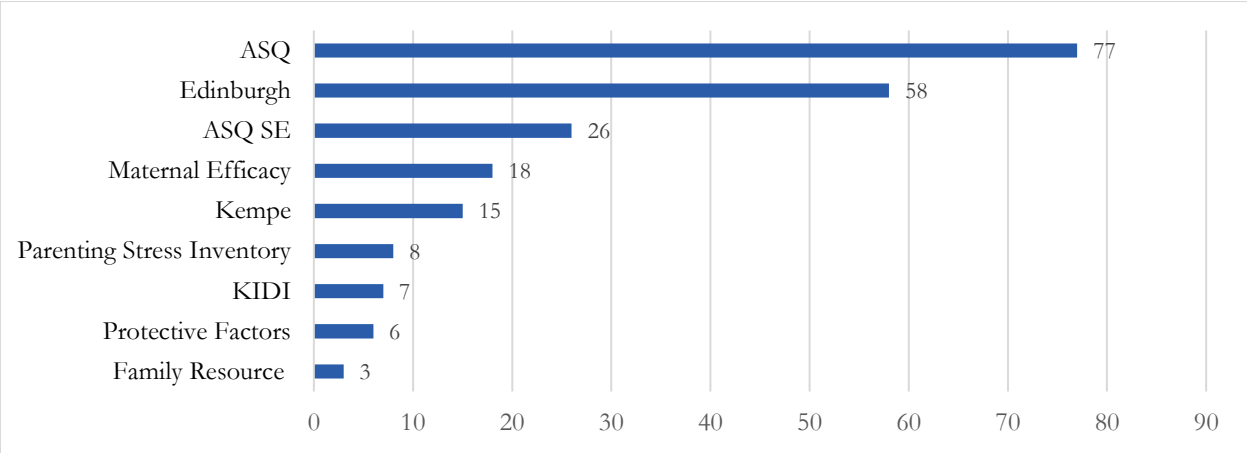
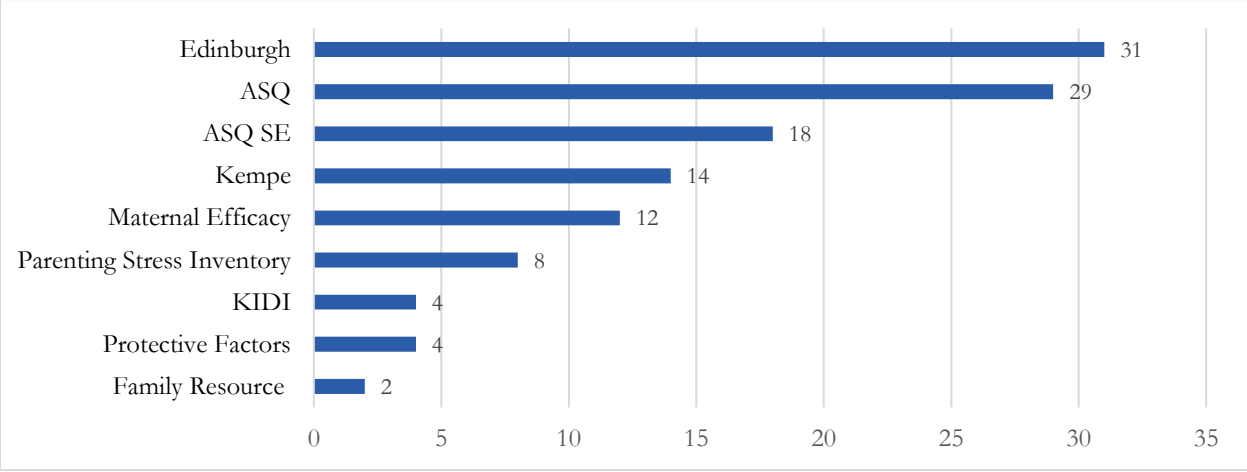


Figure 15 shows the number of pilot clients with whom home visitors and doulas completed different assessments at least once. By far, the two most commonly administered assessments were the Edinburgh Postnatal Depression Scale and the Ages and Stages Questionnaire.

Figure 16. Frequency of Assessments as Measured by the Number of Pilot Clients

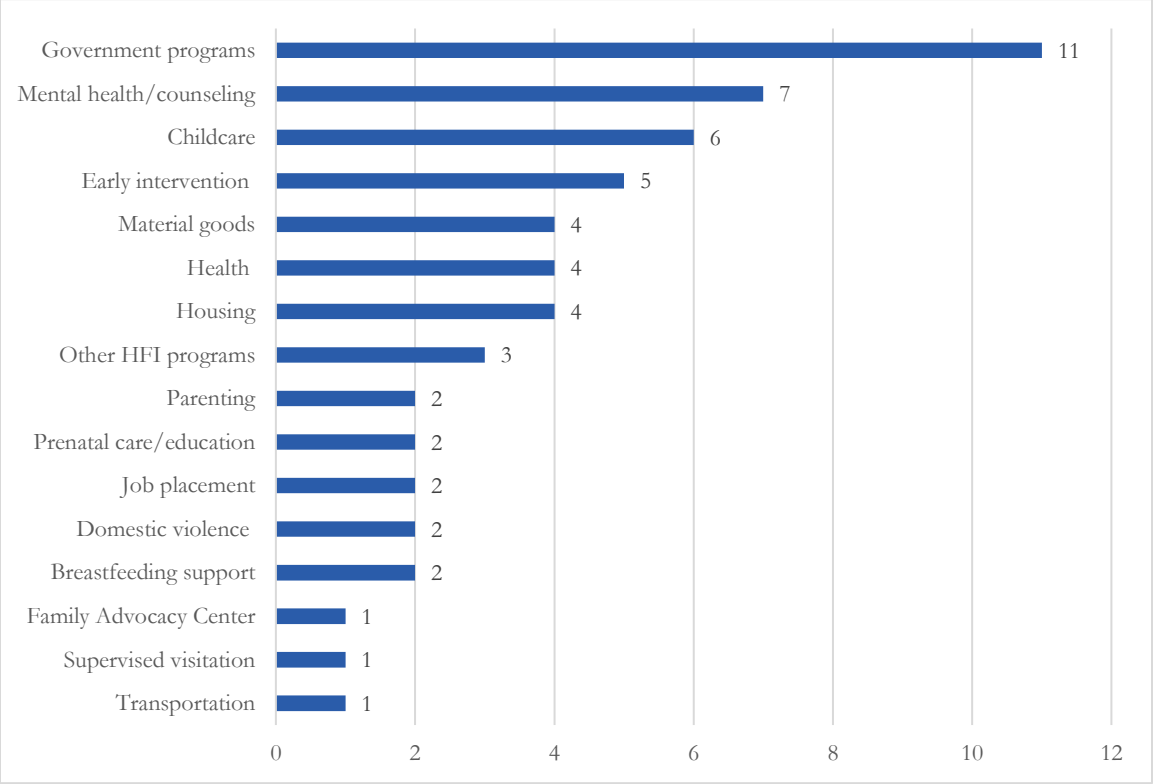


Validation studies of the Edinburgh Postnatal Depression Scale have used cutoff scores ranging from as low as 9 to as high as 13 to determine who should be referred to a mental health

professional for a clinical diagnosis.[34] Of the 31 pilot clients who were screened for depression using the Edinburgh Postnatal Depression Scale, 9 had a score of 9 or more and 2 had a score of 13 or more.

Home visitors and doulas referred 21 of the pilot clients to another program or service. Figure 17 shows the number of pilot clients who were referred to different types of services. Pilot clients were most likely to be referred to government programs, such as WIC, TANF, SNAP and LIHEAP. This was followed by referrals for mental health or counseling services, childcare and early intervention services. Importantly, home visitors or doulas referred six of the pilot clients with scores of 9 or higher on the Edinburgh Postnatal Depression Scale---including both pilot clients who had scores of 13 or more---for mental health or counseling services.

Figure 17. Types of Referrals



*Material goods includes referrals to programs that provide clothing, furniture, or baby items.

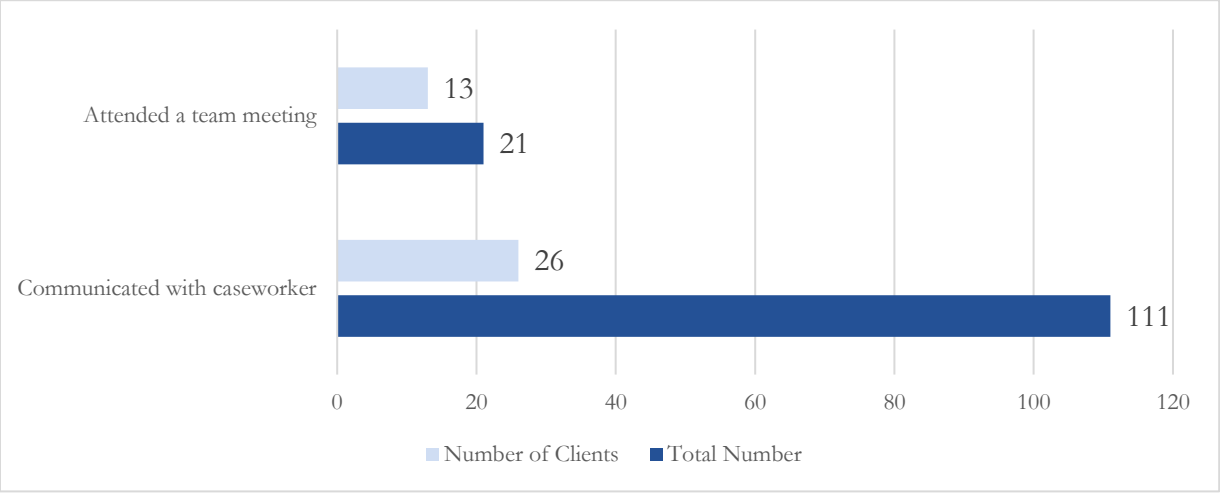
[34] Gibson, J., McKenzie-McHarg, K., Shakespeare. J., Price, J., & Gray, R. (2009) A systematic review of studies validating the Edinburgh Postnatal Depression Scale in antepartum and postpartum women. *Acta Psychiatrica Scandanavica, 119*, 350-364.

Cross Systems Collaboration

A major goal of the pilot was to increase collaboration between home visiting programs and the child welfare system. It was expected that home visitors and doulas would communicate regularly with the child welfare caseworkers of pilot clients. Home visitors and doulas did report 111 communications with caseworkers on behalf of 26 pilot clients (Figure 18). However, communication between home visitors or doulas and caseworkers was typically infrequent and irregular at best. Some home visitors reached out to the caseworker(s) for their pilot client(s) and received no response; others did not reach out.

It was also expected that home visitors and doulas would attend their pilot clients' Child and Family Team Meetings (CFTMs). Home visitors and doulas did report attending 21 CFTMs or Clinical Intervention for Placement Preservation (CIPP) meetings on behalf of 13 clients. In many cases, however, home visitors or doulas were not notified that a meeting had been scheduled or were notified but not informed of its purpose. To remedy this situation, a member of the core team from TPSN began sending emails with information about upcoming CFTMs to both caseworkers and home visitors.

Figure 18. Collaboration with Child Welfare System



Child Welfare Outcomes

Pregnant and parenting youth in care were chosen as the pilot's target population in part because research has found a high rate of child maltreatment among young parents in care. The results of our analysis of the child welfare data are consistent with the findings from that research. Before turning to our results, two caveats are in order. First, the evaluation was not designed to measure the effects of providing home visiting services to pregnant and parenting youth in care. Hence, we cannot draw any conclusions about the impact of this intervention on their child welfare outcomes. Second, the pregnant and parenting youth who participated in the pilot were referred for home visiting services because they were identified as needing parenting supports. In other words, they were selected for the intervention because their risk for child maltreatment was high.

Twenty five of the 41 pilot clients who were parents during some or all of the pilot were investigated for child maltreatment involving their child: six before they enrolled in the pilot (or before the pilot began), 17 while they were enrolled in the pilot, and seven after the end of their pilot enrollment (Table 5). All of the 25 parents who were the subject of an investigation involving their child were investigated for allegations of neglect. Nine were also investigated for allegations of physical abuse.

Table 6. Number of Parents with Child Maltreatment Allegations

	Ever	Pre-enrollment	While enrolled	Post-enrollment
All allegations	25	6	17	7
Neglect	25	6	16	7
Physical abuse	9	4	4	1

Table 6 shows the number of parents with abuse or neglect allegations by allegation type. Most of the parents who were investigated for neglect were investigated for substantial risk of physical injury (allegation 60) or inadequate supervision (allegation 74). Most of the parents who were investigated for physical abuse were investigated for substantial risk of physical injury (allegation 10)

Table 7. Number of Parents with Allegations by Neglect and Abuse Type

	Ever	Pre-enrollment	While enrolled	Post-enrollment
Neglect				
Environmental Neglect	1	0	1	0
Failure to Thrive	1	0	1	0
Inadequate Clothing	1	1	0	0
Inadequate Food	1	0	0	1
Inadequate Shelter	1	0	0	1
Inadequate Supervision	13	5	6	3
Medical Neglect	2	0	2	0
Poison	1	1	0	0
Substantial Risk of Physical Injury	23	5	14	6
Physical abuse				
Cuts, Bruises, Welts, Abrasions or Oral Injuries	1	0	0	1
Substance Misuse	1	1	0	0
Substantial Risk of Physical Injury	7	3	4	0

Sixteen of the 25 parents who investigated for child maltreatment involving their child had at least one indicated allegation: four before they enrolled in the pilot (or before the pilot began), 11 while they were enrolled in the pilot, and two after their pilot enrollment ended (Table 7). All the parents who had an indicated allegation involving their child had an indicated allegation of neglect. Only three had an indicated allegations of physical abuse.

Table 8. Number of Parents with Indicated Child Maltreatment Allegations

	Ever	Pre-enrollment	While enrolled	Post-enrollment
All indicated allegations	16	4	11	2
Neglect	16	4	11	2
Physical abuse	3	2	1	0

Table 8 shows the number of parents with indicated neglect and abuse allegations by allegation type. Most of the parents who had an indicated neglect allegation had an indicated neglect allegation for substantial risk of physical injury (allegation 60). All three parents who had an indicated physical abuse allegation had an indicated physical abuse allegation for substantial risk of physical injury (allegation 10).

Table 9. Number of Parents with Indicated Allegations by Neglect and Abuse Type

	Ever	Pre-enrollment	While enrolled	Post-enrollment
Neglect				
Environmental Neglect	1	0	1	0
Failure to Thrive	1	0	1	0
Inadequate Clothing	0	0	0	0
Inadequate Food	1	0	0	1
Inadequate Shelter	1	0	0	1
Inadequate Supervision	5	1	3	1
Medical Neglect	2	0	2	0
Poison	0	0	0	0
Substantial Risk of Physical Injury	15	4	10	1
Physical abuse				
Substantial Risk of Physical Injury	3	2	1	0

Another way of looking at these child maltreatment data is to focus on the number of allegations rather than on the number of parents involved (Table 9). Parents were investigated for a total of 88 child maltreatment allegations: 28 were made before they enrolled in the pilot (or before the pilot began), 38 were made while they were enrolled in the pilot, and 22 were made after their pilot enrollment. Ninety percent (79 out of 88) of those allegations involved neglect.

Table 10. Number of Child Maltreatment Allegations

	Ever	Pre-enrollment	While enrolled	Post-enrollment
All allegations	88	28	38	22
Neglect	79	24	34	21
Physical	9	4	4	1

Table 10 shows the number of neglect and abuse allegations by allegation type. Almost two thirds (50 out of 79) of the neglect allegations involved substantial risk of physical injury; another quarter (19 out of 79) involved inadequate supervision. Seven of the nine physical abuse allegations also involved substantial risk of physical injury.

Table 11. Number of Child Maltreatment Allegations by Neglect and Abuse Type

	Ever	Pre-enrollment	While enrolled	Post-enrollment
Neglect				
Environmental Neglect	1	0	1	0
Failure to Thrive	1	0	1	0
Inadequate Clothing	1	1	0	0
Inadequate Food	2	0	0	2
Inadequate Shelter	2	0	0	2
Inadequate Supervision	19	7	8	4
Medical Neglect	2	0	2	0
Poison	1	1	0	0
Substantial Risk of Physical Injury	50	15	22	13
Physical abuse				
Cuts, Bruises, Welts, Abrasions or Oral Injuries	1	0	0	1
Substance Misuse	1	1	0	0
Substantial Risk of Physical Injury	7	3	4	0

Just under half (42 out of 88) of the allegations for which parents were investigated were indicated: eight before they enrolled in the pilot (or before the pilot began), 24 while they were enrolled in the pilot, and 10 after their pilot enrollment (Table 11). Ninety-three percent (39 out of 42) of the indicated allegations involved neglect.

Table 12. Number of Indicated Child Maltreatment Allegations

	Ever	Pre-enrollment	While enrolled	Post-enrollment
All indicated allegations	42	8	24	10
Neglect	39	6	23	10
Physical abuse	3	2	1	0

Table 12 shows the number of indicated neglect and abuse allegations by type. Almost two thirds (25 out of 39) of the indicated neglect allegations involved substantial risk of physical injury; another quarter (6 out of 25) involved inadequate supervision. All three of the indicated physical abuse allegations also involved substantial risk of physical injury.

Table 13. Number of Indicated Allegations by Neglect and Abuse Type

	Ever	Pre-enrollment	While enrolled	Post-enrollment
Neglect				
Environmental Neglect	1	0	1	0
Failure to Thrive	1	0	1	0
Inadequate Clothing	0	0	0	0
Inadequate Food	2	0	0	2
Inadequate Shelter	2	0	0	2
Inadequate Supervision	6	1	4	1
Medical Neglect	2	0	2	0
Poison	0	0	0	0
Substantial Risk of Physical Injury	25	5	15	5
Physical abuse				
Substantial Risk of Physical Injury	3	2	1	0

Another indicator of child welfare services involvement we examined was placement in out-of-home care. Ten of the parents had a child placed in care: two before they enrolled in the pilot (or before the pilot began), eight while they were enrolled in the pilot, and one after the end of her pilot enrollment. The parent whose child was placed in care after then end of her enrollment in the pilot was one of the parents who had a child placed in care before enrolling in the pilot (or before the pilot began). All of the children who were placed in care while their mothers were enrolled in the pilot were still in care when the pilot ended.

Major Themes

In this section, we present the major themes that emerged from our interviews with the parenting youth who participated in the pilot and with home visitors, doulas and supervisors. In some cases, we supplement the qualitative interview data with quantitative data from other sources.

Factors Influencing Engagement

Several factors influenced young people's decision to engage in home visiting services.

Choice is important

A core principle of home visiting services is that they are voluntary. This distinguishes them from many of the services that youth in foster care receive. Most of the parents we interviewed described their participation in home visiting services as voluntary and appreciated being able to choose whether or not to participate. They made the decision to enroll; the decision was not made by their caseworker or by a judge.

The parents we interviewed drew a sharp distinction between choosing to work with their home visitor or doula and being required work with the other helping professionals in their lives (e.g., case workers, residential staff, or therapists). This how one parent described the importance choice:

> I like that you got the opportunity to choose whether – if you wanted that person to be around you or not. You had the opportunity to say, 'I don't like this person. I don't want them around, feel comfortable with having meetings with them.' You have a choice.

However, not every parent we interviewed perceived her decision to participate in home visiting services as voluntary. This was particularly true of the parents who were in residential care. Some of these parents were told by staff that they were required to participate in home visiting services and worried that they would be viewed as non-compliant they refused. One parent feared staff would document any canceled visits and point to them as evidence that she was not a good parent.

This is consistent with what we heard from a number of home visitors. Home visitors from three different HFI programs reported that their pilot clients were under the (mistaken) impression that their participation in home visiting services was mandatory. One home visitor recounted what happened when a pilot client in residential care called her to cancel a visit. The home visitor heard staff tell the pilot client she couldn't cancel, which led to a verbal altercation

between the pilot client and staff. Although the visit took place, the home visitor emphasized to her pilot client that it was alright for her to cancel or reschedule visits sometimes.

The parents we interviewed also appreciated being able to make decisions about the nature of their participation including when and where to meet as well as the willingness of their home visitors and doulas to reschedule visits, video chat, or accommodate their school or work schedules.

Confidentiality matters

All of the parents we interviewed talked about confidentiality. For the most part, they trusted that what they told their home visitors or doulas would be kept confidential, with the exception of any disclosures that would trigger mandated reporting. Consequently, some parents reported feeling more willing to share information with their home visitor or doula than with other helping professionals.

Confidentiality was particularly salient for parents in residential care. Some worried that information shared with their home visitors or doulas might be communicated to staff or to other residents working with the same home visitor or doula. However, others trusted that their confidentiality would be protected.

> I know anything I say, it won't go out to anybody else because I might share stuff with them about stuff that I know that they're not gonna go back to [residential] staff and say, 'Oh, [Client] said you were _____.' I know they're not gonna do that.

Dependability is valued

The parents we interviewed could count on their home visitors and doulas to do what they said they would do. This sentiment was captured by one parent who remarked that her doula "doesn't break promises." Home visitors and doulas kept appointments, arrived on time, and brought whatever materials or resources they had agreed to provide. For parents, knowing that they could rely on their home visitor to come to a scheduled visit with diapers when they were running out was important. This was not the experience these parents had had with other helping professionals who did not always keep appointments or follow through when they said they would do something. The dependability of their home visitors and doulas went a long way when it came to developing trust and sustaining engagement.

Need for parenting education

A number of the parents we interviewed voiced doubts about their ability to parent.

> I don't wanna be a bad parent, but I definitely didn't have that much help from my family, like with teaching me what to do…and how to – what's right and what's wrong, what you're supposed to do.

> I wanted to opportunity to be a better mother, 'cause I didn't know how to be a mother for my son, I don't know, and this'd be the great opportunity for me to have [my home visitor] be a part of my parenting life.

The need for help with parenting expressed by these parents motivated them to participate in home visiting services. They felt comfortable sharing concerns about their parenting with their home visitors who would answer their questions and provide them with advice in a non-judgmental way.

Desire for baby items

The incentives that some HFI programs could provide was another reason some of the parents we interviewed participated in home visiting services. Pilot clients were able to earn "baby bucks" for engaging in certain activities, such as attending a parent group, keeping appointments, attending school, or going to the pediatrician, and could redeem those "baby bucks" for baby items such as diapers, clothing, formula, bottles, toys, car seats, or swings in the HFI program's "pantry."

Building trusting relationships is challenging but key

The home visitor-client relationship is central to the HFI model. By providing support to parents, home visitors help parents support their children. Home visitors use this parallel process to encourage positive parent-child interactions, promote healthy child development, and enhance family functioning.

Youth Perspective

Put simply, pilot clients loved their doulas and home visitors as well as the services that HFI programs provide. Their faces often lit up when asked to talk about their home visitors and doulas who they described as "really special."

Like many youth in care, the parents we interviewed had had relationships with an ever changing cast of foster parents, caseworkers, therapists, and other adults whose job it was to help them. Most reported that they had been able to build a trusting relationship more quickly with their doula and/or home visitor than with the other helping professionals in their lives. They attributed this to the non-judgmental, caring approach their doulas and home visitors used. As one parent explained,

> I'm not the type of person that when I meet somebody I feel like I can trust them and talk to them. With [my doula and home visitor] it just different like, it just felt like they understood me.

As a result of this trust, the parents we interviewed felt they could talk to their doulas and home visitors about "anything and everything." Parents reported turning to their doulas and home visitors for parenting and relationship advice, child development information, and in some cases, advocacy with DCFS. Having a home visitor or doula to turn to may have been especially important to parents in residential care. These parents worried that asking staff for help caring for their babies might be interpreted as evidence that they were not capable of parenting. By contrast, they felt comfortable speaking honestly about needing help with their home visitors.

Some parents also turned to their home visitors and doulas during periods of crisis. For example, one parent who had been beaten by her child's father described how her home visitor had provided emotional support and referred her to domestic violence services.

> When I had told [my home visitor] about that stuff, immediately she gave me a list of resources about things where he could go to, and where, what we could do next to – like she gave me all those resources, which was really nice because I had the power to make the decision on my own.

Another explained how her doula helped her identify and seek treatment for postpartum depression.

> When I was sad, or when I was going through my post-partum depression phase, she was there. She's the one that actually warned me about, she prepared me to know the signs of post-partum depression.

Perhaps the clearest example of how much these parents trusted their home visitors was the story shared by a parent whose home visitor had accompanied her to the hospital after she had been raped and supported her decision to share what happened with child welfare agency staff. This parent recalled how critical her home visitor's support was, particularly at the hospital where the home visitor "was talking to me. She was comforting. She was just there. Her being there just especially the whole time meant a lot."

Although trust is important for sustained engagement in home visiting services, a few pilot clients may have become too attached to their home visitor or doula. One pilot client who was pregnant with her second child refused to work with another home visitor when the home visitor she had been working with for over a year went on maternity leave. This pilot client was unresponsive when both a supervisor and doula tried to engage her so the program terminated services. Another pilot client who had a very strong relationship with her home visitor moved to another area of the state. Although she readily agreed to be transferred to another HFI program that was participating in the pilot, the relationship with her new home visitor never "clicked" and services were eventually terminated. As both of these examples illustrate, pilot clients disengaged from services when the person they had grown to trust was unable to continue in their role.

Home Visitor/Doula Perspective

The home visitors and doulas we interviewed were committed to building genuine, caring relationships with their pilot clients. Some were able to establish relationships with their pilot clients relatively quickly. Others described their pilot clients as being guarded, distrustful and slow to open up:

> I think these girls have a general distrust of others…and of systems and people who are there to support them...They've been disappointed before…felt like the people that were supposed to be there to support them were not. And so…they're kind of expecting me to do the same thing. 'You'll come visit me a couple of times and then you'll stop coming around, or you won't follow through, and then that's the end of that.' So I feel like just now after working with them for a few months…I'm starting to get through for them to trust me a little more. I feel like I'm always being tested…like with all the cancellations…"How long are you gonna keep trying for?"

Distrust was only one of several factors that made establishing relationships with some pilot clients difficult. Sometimes pilot clients were hospitalized, in detention, or "on run"---often unbeknownst to their home visitor or doula. Other times pilot clients were nonresponsive---not because they didn't want services, but because so much else was happening in their lives.

Another factor that some home visitors and doulas found particularly frustrating was the frequency with which some pilot clients missed their scheduled visits. Pilot clients seemed to miss their scheduled visits more frequently than the typical home visiting client. For example, one home visitor was only able to complete four visits in a 3 month-period with a pilot client who was supposed to be visited weekly. Her other clients might miss one or two weekly visits per quarter.

Despite these challenges, home visitors and doulas did develop trusting relationships with some of their pilot clients, in part, by recognizing that a non-judgmental approach was key to gaining their client's trust. One home visitor described herself as "someone that [her pilot client] can ask questions to and she...wouldn't feel judged." Another tried to keep in mind the trauma her pilot clients may have experienced and the impact of those experiences on their behavior. She recognized, "It would be very easy to become disengaged from them because of how hard it is to engage them."

Home visitors and doulas used a number of different strategies to build and maintain relationships with their pilot clients, with varying degrees of success. These strategies included making multiple attempts to visit in a single week, waiting at the child welfare office on "check day," and texting when they were near where their pilot client was living. One home visitor gave her phone number to a pilot client she had not seen for two months and reminded her "that you can still reach out to me and I could still try to find ways to provide a service for you."

Need for a Natural Support System

Most of the doulas and home visitors we interviewed described their pilot clients as having greater needs than typical home visiting clients. They attributed this to the fact that their pilot clients often lacked a natural support system. One home visitor explained that her pilot clients don't "have somebody that they could call or…a friend group that could help them." Another described her pilot clients as "having zero family support."

Some home visitors described themselves as providing what a natural support system otherwise would. One explained that if her other clients had questions, they "might just ask their mom,…their grandma,…or a friend…but I was that person [her pilot client] would call or text and ask those questions to." Another home visitor reported that she used Facetime throughout the week to communicate with her pilot clients because they just needed to talk.

This "need to talk" was something that we heard about from a number of home visitors. For example, one home visitor described having "very deep conversations" with a pilot client who shared her feelings about taking her child to visit his father in jail and her son's reactions to that visit.

A number of home visitors and doulas told us that some of their pilot clients came to view them as playing a number of different roles including mother, teacher, therapist, and auntie. The parents we interviewed used these same words to describe their doulas and home visitors. For example, we interviewed one parent who described how her home visitor "kind of became a mother figure, because I don't have a lot of those. I don't have any of those."

Even if pilot clients did not use these words to describe their home visitors and doulas, they relied on their home visitors and doulas to provide the support that a natural support system otherwise would. One parent we interviewed described how her home visitor helped her through postpartum depression:

> I could tell I was going through stuff. I texted her any time of night. She would respond and call or talk to me; told me everything would be okay.

This lack of a natural support system is one of the reasons having a doula-supported birth may be especially important for youth in care. One doula reported that she was the only person present to support her pilot client when her pilot client gave birth. Another described the experience of a pilot client who had wanted the baby's father to be present at the birth:

> Then she waited and waited and waited…the baby was crowning and she wasn't pushing because she was waiting for dad. She was holding on to the baby until dad came, and dad came. For me, the most disappointing part of it all was that when dad did come, he only stayed for maybe 15 minutes and left.

Benefits of home visiting services

Pilot clients benefitted from the services they received from their home visitors and doulas in a number of different ways.

Learning about childbirth

Doulas typically educate their clients about what to expect during childbirth including the medical interventions, such as epidurals, that might be used. One doula reported needing to review basic anatomy (e.g., uterus, cervix, umbilical cord, and placenta) with each of her three pilot clients before talking about those medical interventions because her pilot clients were less familiar with their bodies than most clients with whom she works.

Pilot clients also learned what to expect during labor. One doula, who was present at the birth of her pilot client's baby, described how proud she was of her client for "coping so well with [her] contractions. Her pilot client remembered what she had learned from her doula and "kept on breathing and saying I can do it. I can do it."

Learning about child development

Among the ways pilot clients benefited from their participation in home visiting services was that the knowledge they gained about child development helped them understand their baby's behaviors. This is important for two reasons. First, parents with a history of abuse or neglect may be less responsive to their children than their peers who have not experienced maltreatment.[35] Second, adolescent parents are more likely to respond inappropriately to their child's developmentally appropriate behaviors than parents who are older.[36]

Doulas and home visitors described their pilot clients as knowing less about child development than their other clients. This is not surprising; research suggests that adolescent parents often have limited knowledge about child development.[37] Despite their lack of knowledge, the parents we interviewed were all interested in and concerned about the development of their babies, and several identified the information their home visitors shared about child development as one of the main benefits of their participation in home visiting services.

Home visitors asked parents to share their observations about the development of their children and conducted developmental assessments. They often reassured parents who had concerns

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[35] Bert, S., Guner, B., Lanzi, R., & Centers for the Prevention of Child Neglect (2009). The influence of maternal history of abuse on parenting knowledge and behavior. *Family Relations, 58*, 176–187.
[36] Fulton, A., Murphy, K., & Anderson, S. (1991). Increasing adolescent mothers' knowledge of child development: An intervention program. *Adolescence, 26,* 73-81.
[37] Tamis-Lemonda, C., Shannon, J., & Spellmann, M. (2002). Low-income adolescent mothers' knowledge about domains of child development. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health, 23*, 88-103.

about their baby that their child's development was normal. One parent noted that her home visitor "told me every baby develops at their own pace."

Home visitors also offered strategies to promote healthy development. One home visitor described how one of her pilot clients had turned to her with some developmental concerns:

> She would ask me different ways to do tummy time because she had concerns about the baby dropping her head on the floor and hurting herself… She has been thinking about all these things and wanting to protect and keep her baby safe...She was looking for more ways to help strengthen her baby's neck and some other activities to do with her.

One parent we interviewed, who struggled with her fussy baby's behaviors, described how her home visitor helped her:

> When [my baby] was first born, she had colic issues a lot. She would give me hope so that it wouldn't be so bad about that…I never knew tummy time was such a help, but that was one of the things I've learned.

Home visitors talked with their pilot clients about the importance of talking and reading to their babies to promote speech and language development. One home visitor described the activities she engaged in with her pilot clients to promote their babies' speech and language development:

> We've started talking more about his language development and things like that…. I try to make a lot of homemade books. … Give him some more verbal kinds of things…like let's say if she wants to work on body parts with him or something, make a book around that.

Home visitors reported hearing from their pilot clients what the experience of reading and talking to their babies had been like. Some pilot clients even showed their home visitor the books they had read. One parent described how she had applied what she learned from her home visitor about the importance of reading and talking to her baby,

> Like reading every day, now she is talking baby talk, and she's not even three months yet, and [my home visitor] told me it depends on how much I talk to her and she'll start responding, and she does. I'll talk to her and she'll start smiling.

The parents we interviewed appreciated both the advice their home visitors gave them about the importance of early literacy and the access to books and other tools they provided. One parent talked about how her home visitor had encouraged her son to read by bringing him books.

> Reading, but we made that a routine type of thing right before we go to bed. She brought us books every week, 'cause I told her that's something I wanted to work on with him, reading, because we haven't got a chance to do that as often as we should,

> and so she brought him a book every week. A different book and he read it. He still has all the books.

Learning parenting skills

The parents we interviewed appreciated being able to ask their home visitors questions about parenting. Conversely, home visitors were encouraged by the questions pilot clients asked about caring for their children. One home visitor described how she responded in a non-judgmental way to a pilot client who wanted to know how to dress her son for the cold weather.

Several of the home visitors we interviewed were encouraged by their pilot clients' parenting skills. One described how her pilot client talked to and tried different things with her child when he was having a tantrum. Another home visitor recounted how she and a doula had helped a parent in residential care who was unable to get her baby to stop crying. When this happened, staff would intervene, leaving the parent to question her parenting abilities. The home visitor and doula walked the parent through the 5S's technique for calming babies, which the parent was able to use successfully.[38]

Parents reported learning how to feed, bathe, and otherwise care for their infants from their home visitors, and this guidance contributed to feeling successful as new parents. One parent described how her doula and home visitor helped to ease her fears about her baby not eating enough by teaching her how to pump breast milk for her baby:

> She helped me out right away with the pump, and I felt so relieved because I felt like I could see how much he was eating. I could – because I was nervous he wasn't eating enough. I was just like – and, you know, it's like I was nervous he wasn't eating enough. I was like, "How do I produce enough milk? How do I do this?" And they were able to tell you all that stuff. You know? I was given bags to store for my breast milk. They didn't have to do that, but they did.

Parents also learned about sleep training and safe sleep from their home visitors. One parent described how her home visitor helped her establish a bedtime routine with her baby:

> So now we're working on the bedroom routine, 'cause I'm trying to get him to sleep in his own bed because I like my own space. You know I want him to learn okay, that this is your bed, this is your space... I just want now the routine of me trying to make him sleep in his bed every night. It's not going well 'cause he'll cry; he'll get back out and then I have to keep putting him back in. So [my home visitor] was telling me hey, how about this, how about you put him in the bed, while he's laying in the bed you just sit on the floor next to him, next to the bed so that way he's a little comfortable because you're right there. It actually works.

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[38] Karp, H. (2015). *The happiest baby on the block; fully revised and updated second edition: the new way to calm crying and help your newborn baby sleep longer*. New York, NY: Bantam.

Safe sleep was a particularly salient concern for the parents in residential care because of program rules prohibiting co-sleeping. One parent in residential care learned from her home visitor, "how she's to sleep, why we can't co-sleep, and when to start feeding her more."

Home visitors also helped pilot clients develop nurturing bonds their babies and become more attuned to their needs. One home visitor noted the "loving" and "nurturing" interactions one of her pilot clients had while talking and playing with her baby. Another described seeing a pilot client and her baby "light up" when the pilot client returned home.

Developing coping skills

Home visitors helped their pilot clients become more attuned to the impact their own behavior could have on their babies. One parent we interviewed told her home visitor that she often became irritated with her fussy baby. Her home visitor explained that a baby can sense when its mother is upset and "gets upset too" and suggested using a self-regulation strategy:

> She said, 'Maybe you should take a break, ask staff to watch him for a minute, and you can calm yourself down.' I did that, and he calmed down. I calmed down.

Another parent described what she learned from her home visitor about how her mental health could adversely affect her parenting and how she can prevent that from happening:

> [My home visitor] feels if she talks to me about the things that are going on, it's better to talk about it than keep it inside 'cause it can affect how like my relationship…So basically, if I'm not in a good mood, it could probably lack my parenting skills. Like I'll probably sleep all day, won't really give my son no attention if I'm in a depressed mood. So she felt that it's better to just talk about it to check in when we see each other to see how I'm doing and stuff like that.

During their interviews, parents described expressing their anger and frustrations in maladaptive ways that led to unwanted consequences in their relationships. This was especially true for parents in residential care. Home visitors helped them develop self-regulation strategies to use when conflicts arose with staff or other residents. One parent we interviewed followed her home visitor's suggestion to listen to music when feelings escalated in her residential care placement. Another parent explained how she had applied the advice she had received from her home visitor about self-regulation:

> Like with my mood swings, she'd usually just tell me to calm down, and like one time when I got mad at the staff that's working right now, she's like, "No, do not get mad at her. Just apologize to her and tell her what's going on." And that actually helped me because that's one of my favorite staff.

Teaching self-regulation is a part of the parallel process that is central to the HFI model. Home visitors encourage self-regulation in parents so that they can in turn raise self-regulated

children. This process may be particularly important for parents in care who have experienced more trauma than the typical home visiting client.

Developing positive relationships with the fathers of their babies

Home visitors helped pilot clients develop healthy relationships with the fathers of their babies. One home visitor who had "conversations around healthy relationships" with her pilot client was encouraged by the healthy relationship that her pilot client had developed with the father of her baby. Another home visitor described working with a pilot client and her client's partner who was also present during the visits.

> They have opened up about different disagreements that they have had and asked me for a little advice here or there. [I] just give them that space to vent and to talk to each other calmly.

Some of the parents we interviewed talked about the challenges of co-parenting with the father of their child. Home visitors helped pilot clients navigate these co-parenting relationships. One parent expressed gratitude that her home visitor was willing to meet with her and her partner to talk through their co-parenting conflicts. Another parent appreciated the way her home visitor had promoted co-parenting by including the father of her baby in visits while she was still pregnant.

> Well, I felt like she just really included him. 'Well, [Dad], how do you feel about [Mom] being pregnant, or what do you do when [she] has contractions?'...[S]he would bring him paper just on daughter and daddy time and she would bring me stuff on mommy and daughter time, you know.

These home visitors were not alone in their effort to make the fathers of their pilot clients' babies feel included. Although few pilot clients were living with the father of their baby, at least 10 pilot clients had one or more visits with the father of their baby present.

Factors complicating youth engagement and service delivery

Two factors--placement instability and personal crises-- complicated youth engagement and service delivery. Although we address them separately, we recognize that they often go hand-in-hand.

Placement Instability

Although some pilot clients had relatively stable placements while they were enrolled, others changed placements multiple times. Many pilot clients also experienced one or more non-placement events, such as detention, hospitalization or running away, that disrupted their placements.

This variation in the stability of pilot clients' placements is illustrated by Figures 19 - 22 which show the types and durations of the placement and non-placement events experienced by each of the 43 pilot clients while *they were enrolled in the pilot*. Each bar represents a single pilot client. The bars in Figure 19 represent the 19 pilot clients who experienced fewer than five placement and non-placement events; the bars in Figure 20 represent the nine pilot clients who experienced between five and 10 placement and non-placement events; the bars in Figure 21 represent the nine pilot clients who experienced between 11 and 19 placement and non-placement events; and the bars in Figure 22 represent the six pilot clients who experienced 20 or more placement and non-placement events.

Figure 19. Pilot Clients with Fewer than 5 Placements and Non-Placement Events

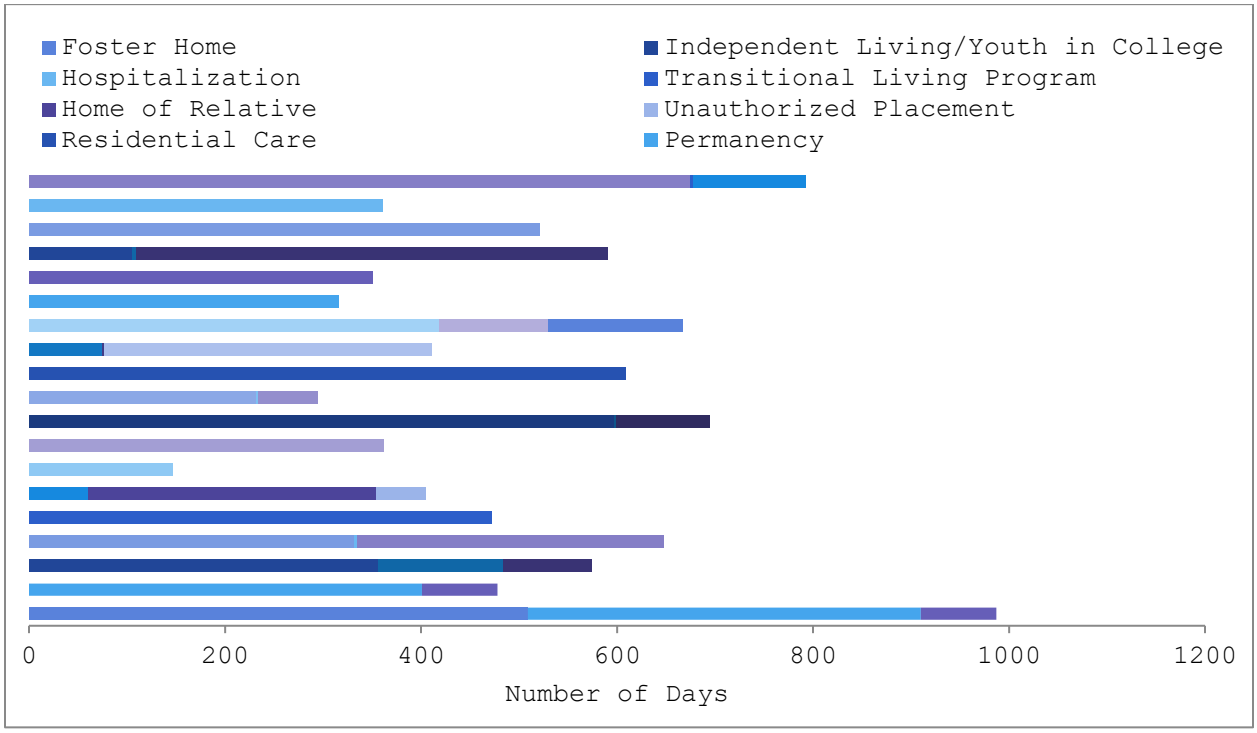


Figure 20. Pilot Clients with 5 to 10 Placements and Non-Placement Events

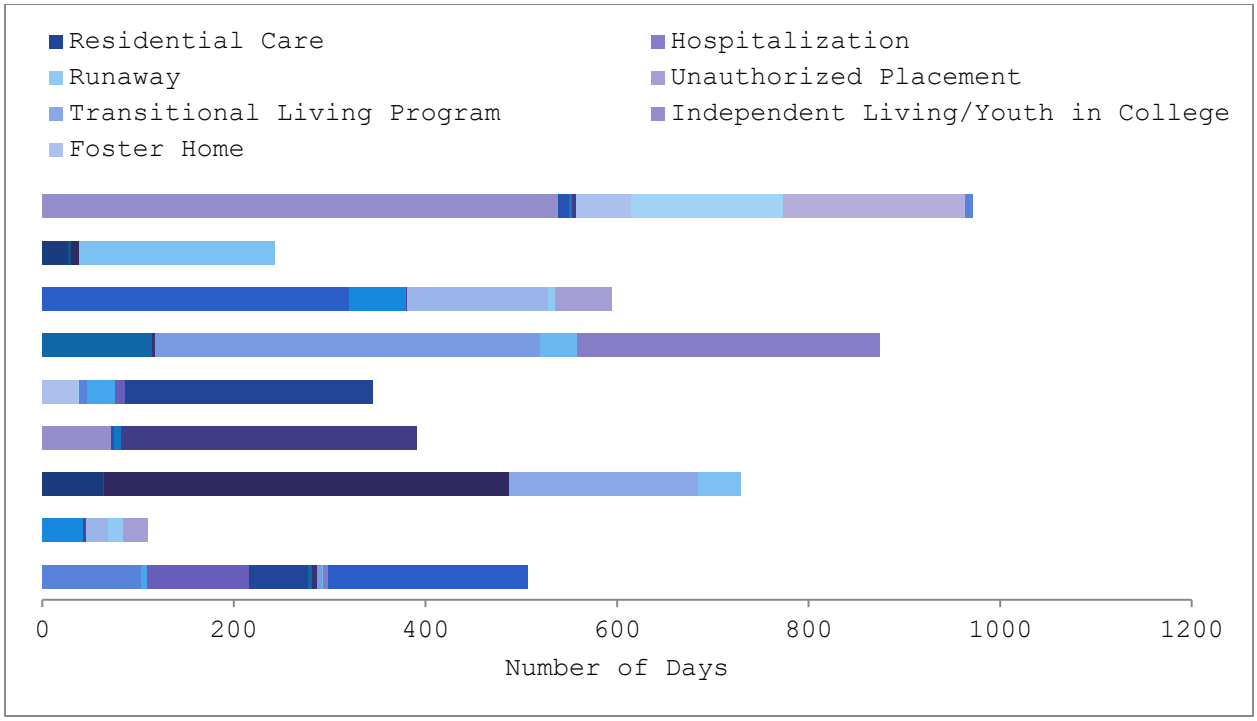


Figure 21. Pilot Clients with 11 to 19 Placements and Non-Placement Events

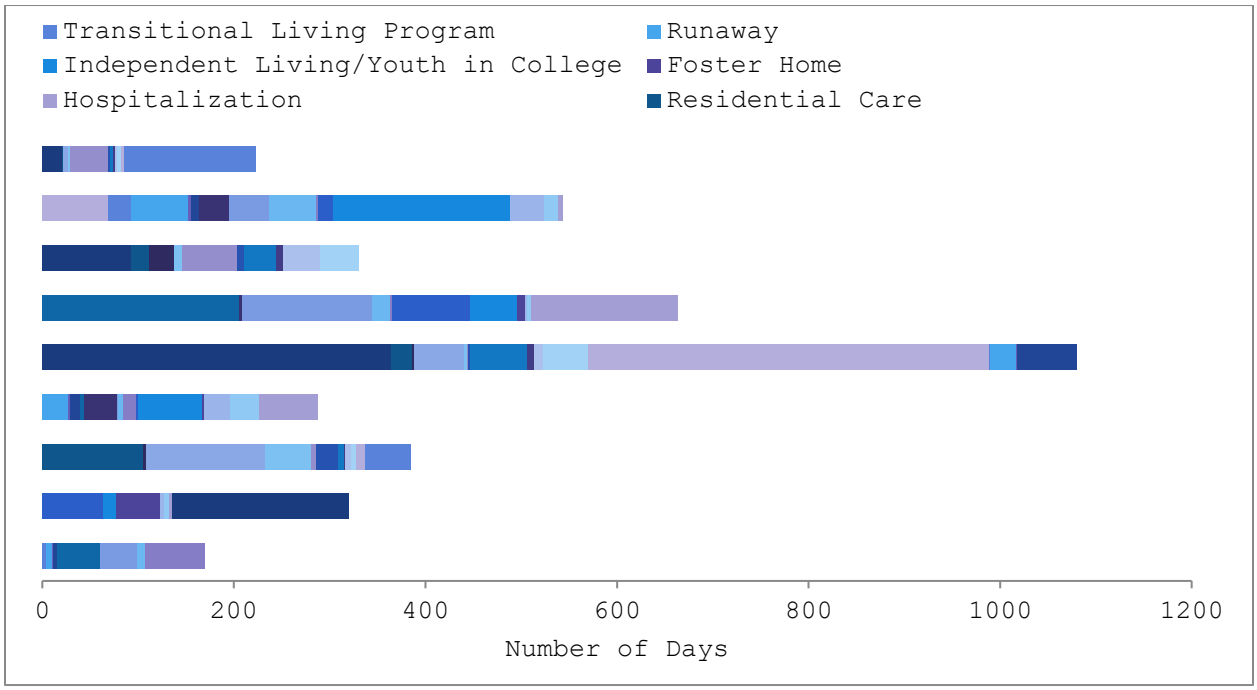
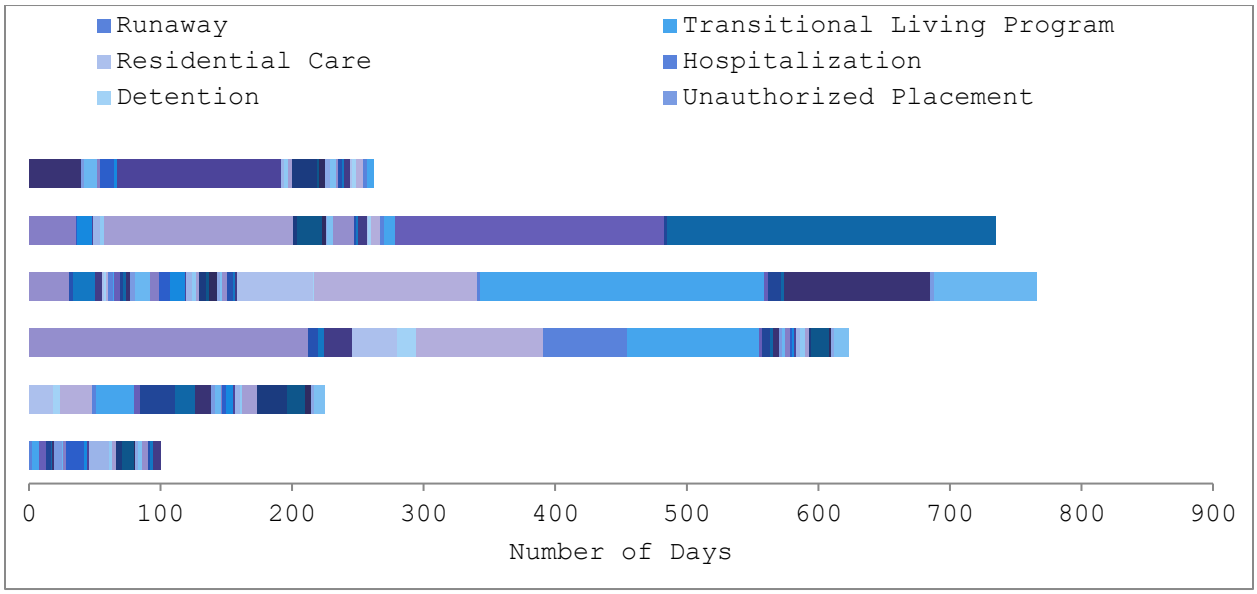
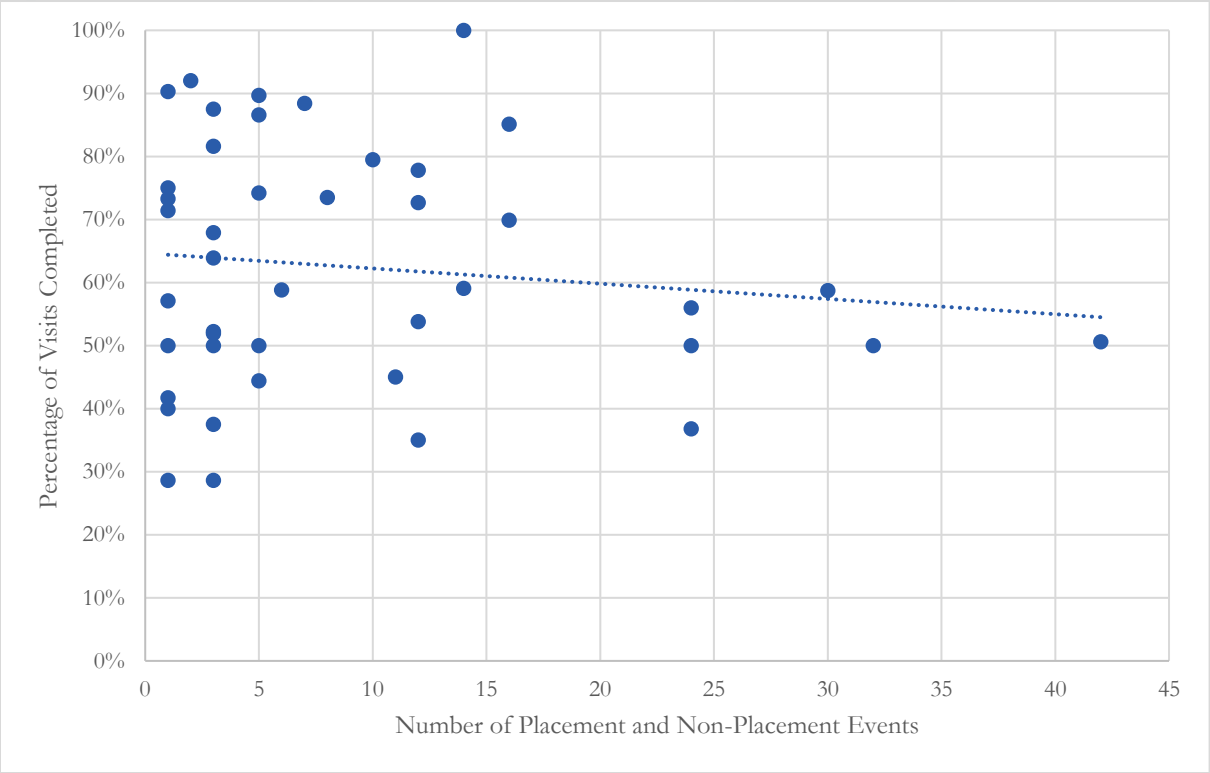


Figure 22. Pilot Clients with 20 or More Placements and Non-Placement Events



We hypothesized that differences in placement instability, including disruptions due to non-placement events such detention, hospitalization or running away, might explain some of the variation we observed across pilot clients in the percentage of visits that were completed (Figure 12). However, our hypothesis was not supported by the data (Figure 23). The relationship between placement instability and visit completion rates is negative (as indicated by the trend line which has a negative slope) but relatively weak (as indicated by the disbursement of the data points around the trend line). Although the completion rate was consistently low for pilot clients whose placements were the most unstable, it was also low for some pilot clients who had relatively stable placements.

Figure 23. Relationship between Placement Instability and Visit Completion



Although we didn't find a strong relationship between placement instability and visit completion rates, home visitors and doulas were not accustomed to working with clients whose living arrangements were so unstable. One home visitor noted that her pilot clients often didn't seem to know where they were going to be living from one day to the next.

Some pilot clients remained in contact with their doula or home visitor while they were on run. However, the parents we interviewed recognized placement instability as a barrier to relationship building. One of the 15 pilot clients who was "on run" at least once while enrolled in the pilot acknowledged that going on run to be with her child's father made it difficult to develop a relationship with her home visitor.

A number of pilot clients were moved to placements outside the catchment area of the HFI program from which they were receiving home visiting services. The impact these placement changes had on service delivery depended on the situation. In some cases, the HFI program made an exception and continued working with the pilot client. In other cases, the pilot client was transferred to another HFI program participating in the pilot whose catchment area included the new placement. However, those transfers were rarely smooth. There was often a long delay between when services from the first program ended and services from the second program began and pilot clients did not always engage with the new home visitor. When neither was an option, the pilot client was either transferred to a home visiting program that was not participating pilot or home visiting services were terminated.

Personal Crises

Youth engagement and service delivery were also complicated by personal crises. Some of these crises were related to mental health. Two pilot clients in one HFI program were hospitalized for depression. A third pilot client in another HFI program attempted suicide. Other pilot clients were dealing with intimate partner violence.

We interviewed one parent who was being beaten by her baby's father. She was reluctant to call the police because she believed that this would lead to her baby being placed in DCFS care. It was only when she feared for her life that she finally called. The father of her baby was arrested and a safety plan was put into place. Although this mother was able to talk with her home visitor about the intimate partner violence, she was less engaged in services because of it.

> There was abuse going on, and I didn't know how to handle it. And she opened up to me like about her past, and she was able to sort of relate with me as a person and tell me that someone – tell me straight up that she's not perfect. Everyone makes mistakes, but it's whether or not they're willing to change.

One parent we interviewed described how her repeated detention made it difficult to remain consistently engaged in home visiting services.

> Well, there was a time where there was gaps because I was in and out of jail for a little bit and in those times it was kind of hard because I had to get my home visitor approved and everything else to come see me. She still came and seen me and brought me really good information.

This parent was eventually placed in residential care and was able to maintain weekly visits with her home visitor.

Most of the parents we interviewed remained engaged with home visiting services despite the personal crises in their lives. Sometimes personal crises strengthened the home visitor-client relationship. One of the parents we interviewed described the supportive response she received when she shared how she was feeling with her home visitor:

> Like people in the past, when I tell them specific stuff, and they leave out of my life because of that stuff, 'cause they think I did something wrong, I automatically shut down. And when I told [my home visitor], she gave me good advice, like, "Don't give up on yourself. You're too beautiful to give up on yourself, and if you gave up on yourself I would miss you." She's one of the people that I can trust now.

However, some parents were unable to engage in home visiting services because so much else was going on in their lives. For example, one parent who had recently aged out of care was struggling to balance work and school. After being suspended from her job, she sold most of her furniture in order to pay her rent and was on the verge of homelessness. She terminated services after seeing her home visitor only a few times.

Some home visitors wondered if their pilot clients were receiving the therapy or counseling they seemed to need to deal with their personal crises. They also noted that their pilot clients were turning to them for a more intensive level of intervention than they felt qualified to provide.

Navigating the child welfare system is challenging for home visitors

Home visitors have questions about DCFS services/resources

One aspect of the cross-training that home visitors, doulas and supervisors found particularly helpful was the information they received about the resources available to pregnant and parenting youth in care. These resources include cribs, car seats and the $107 monthly infant supplement. One home visitor was able to share what she had learned about these resources with a pilot client who did not know what DCFS would provide when her baby was born.

Despite attending the cross-training, home visitors still had a limited understanding of "how DCFS works" and lacked basic information such as the age until which youth can stay in care, the frequency with which youth meet with their caseworkers, and caseworkers' responsibilities. One home visitor put it this way:

> I need a little bit more training on just kind of knowing where these girls are coming from, learning a little bit more about the system and how it works, so that I'm not completely clueless when they're talking about certain things. When they talk about the people that are there to support them, I don't really know what their roles are sometimes, or who to go to for certain things.

This same home visitor was particularly confused about what her pilot clients receive from DCFS.

> They talk about how much money they're receiving from the state every two weeks...[but] they also talk about not having enough money for school or diapers, and so it's confusing to me when they're supposed to be receiving their check every two weeks. I don't know how much other resources to give them, because I've been told that....they can't maybe apply for other services, because their needs are supposed to be met with what they receive every two weeks. So that has been confusing to me.

Home visitors also questioned how well their pilot clients were being prepared for living independently. Their pilot clients seemed to lack of basic independent living skills such as knowing how to budget. One home visitor observed that "nobody is teaching [pilot clients] how to be responsible adults." This led some home visitors to supplement the curriculum they normally use.

Home visitors also offered recommendations for additional training on working with pregnant and parenting youth in care. One home visitor recommended that more training on trauma-informed practice, including training on how to prepare young women who have experienced

sexual abuse for birth and parenting, be provided. Another recommended that training on how to build trusting relationships with clients who are always "on guard" be provided.

Information Sharing

Home visitors grappled with two main issues when it came to information sharing. One issue was how much information they needed or wanted about a pilot client's background. Some home visitors believed that knowing about a pilot client's background would be helpful; others disagreed and believed it was not that important. For example, one home visitor questioned whether she really needed to know that her pilot client had been diagnosed with bipolar disorder and had a history of drug use since they "clicked right away" when they met.

A supervisor from one HFI program described the evolution of her thinking about this issue. At first, she and the home visitors she supervises wanted caseworkers to share information about backgrounds of their pilot clients and were frustrated that caseworkers were not providing them with information. Over time, however, they realized that it was better for pilot clients to share information about themselves when they were ready.

> We kind of struggle with like is there a benefit from us knowing? What do we gain from that?...[T]he circumstances don't really matter. It's that relationship. If they turn to us, they're not going to turn to us for help in those areas; they're going to turn to us, because they need more of the emotional support and a safe person to talk to. So anyway, that's...how we changed our minds a little bit in that regard.

By contrast, home visitors and doulas agreed that that having certain information---such as when a pilot client experienced a placement change, went "on run" or was in the hospital or detention-- in a timely manner was essential to their jobs. Lack of information sharing by their pilot clients' child welfare workers meant that home visitors and doulas were often unaware of these events until they learned about them from the pilot's project manner.

The second issue with which home visitors grappled was how much information they could and should share with their pilot clients' caseworkers. Home visitors who were asked to provide progress reports on their pilot clients expressed concern that doing so could undermine the relationships they established and wondered whether caseworkers understood that home visiting services were voluntary and confidential. One HFI program that often works with pilot clients in residential care created a "topic sheet" which they fill out and share with staff after each visit.

Role in Team Meetings

Some of the home visitors we interviewed who attended Child and Family Team Meetings (CFRMs) or Clinical Intervention for Placement Preservation (CIPPs) found their presence to be beneficial. Two home visitors were able to help devise a plan that allowed their pilot client to have supervised visits with their children who were in care. One became aware of her client's

goal plan and learned what she could do to support her client's efforts to achieve her goals. Another learned what was being done to prepare for her pilot client's emancipation, which allowed her to focus on her client's pregnancy.

Other home visitors were uncertain whether being "around that table" was a good idea. In one instance, a home visitor arrived at a CIPP meeting not knowing its purpose, and neither she nor her pilot client knew that the other would be present. Although this did not adversely affect their relationship, it easily could have.

The parents we interviewed also disagreed about whether they wanted their doulas and home visitors to attend meetings or otherwise collaborate with DCFS. Most thought it would be helpful for their doulas and home visitors to attend their CFTMs. They viewed their doulas and home visitors as advocates who could speak on behalf of their parenting skills, particularly if their children had become involved with DCFS. One parent stated that her home visitor could "be at any meeting I have." At the same time, parents wanted some control over how much their doulas and home visitors knew about their abuse and neglect histories. Moreover, not every parent we interviewed wanted her home visitor to attend CFTMs or other meetings. For example, one parent viewed her home visitor as a support for her child and saw no reason for her to be involved with her child welfare case.

Clients in Congregate Care

Several of the home visitors and doulas we interviewed were working with pilot clients who were placed in residential care and transitional living programs. Delivering services to these pilot clients presented challenges but those challenges varied depending on the congregate care provider. One provider did not allow a home visitor to communicate with her pilot client because she was not on the list of individuals with whom the pilot client could communicate. Another would only allow home visitors and doulas to visit pilot clients if staff had advance notice of the visits. At a third provider, staff entered the rooms of pilot clients during visits without knocking.

One residential care provider with whom several pilot clients were placed made delivering home visiting services especially challenging. First, home visitors had to go through staff to schedule visits or otherwise contact their pilot clients. This meant that staff and not the pilot clients had control over whether and when visits would occur. It also made enrolling young women in pilot very difficult---especially in the beginning. Enrollment got easier as home visitors and staff became more familiar with one another.

Second, home visitors were prohibited from visiting with pilot clients in their rooms. Visits could only take place in common spaces where conversation between home visitors and pilot clients might be overhead by staff or other residents. Home visitors expressed concern that this prevented pilot clients from opening up as much as they might in a more private setting.

> We can only meet in the common area, and there's been a few times that that has really irritated [pilot client]. She's like, 'I can't even hear you right now. Everyone is being so loud.' I can tell it's really upsetting her because she always has so many questions and wants more information. We...can't go into her room and talk, even with the door open, which is almost a little bit against our…policy because...we do home visits…where you're most comfortable…and confidentiality. So people are walking back and forth. Maybe she doesn't open up and share as much because there's staff or there's other moms there and she doesn't want them to hear.

Third, home visitors were often unable to spend more than half an hour with their pilot clients, which is about half as long as the typical home visit. Visits were either cut short because pilot clients were scheduled to attend a group or interrupted by chores.

> They have strict schedules. They get home right at 3:30 and they have group at 4:00. So, we just really meet for sometimes 30, 25 minutes right in between that. That's really hard because we're trying to build rapport, but also prepare her for birth. That's hard to do in 20 minutes.

Home visitors raised other concerns about the treatment of pilot clients at this residential care facility. First, although participation in home visiting services is voluntary, staff did not allow a pilot client to cancel a visit she did not feel up to having. Staff also canceled a prenatal appointment at which a doula was supposed to meet her pilot client. Second, contrary to a large body of research on the benefits of responsive parenting behavior, staff admonished pilot clients not to spoil their babies by holding them.[39,40] Finally, on one occasion, child welfare staff asked to speak privately with a home visitor and doula when they arrived for a visit. They were concerned about the pilot client's lack of attachment to her newborn and planned to call the hotline. The home visitor and doula were aware of the problem but did not feel that it rose to the level of a hotline call. They also wished staff had called prior to the visit to discuss their concerns rather than leaving the parent to wonder what was being said about her while she waited for her visit to begin.

Working with multiple pilot clients in this residential care facility created an interesting dynamic. On the one hand, pilot clients did not like sharing "their" home visitor with other residents. Consequently, the HFI program decided not to assign the same home visitor to more than one pilot client. On the other hand, because home visitors became a familiar presence, establishing relationships with pilot clients was not as difficult as it had been. One home visitor noted that her colleague had "already opened that door, so it was an easier way to kind of build that rapport with them.They already kind of trusted us."

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39 Roggman, L., Boyce, L., & Innocenti, M. (2008). *Developmental parenting: A guide for early childhood practitioners*. Baltimore: Brookes Publishing.

40 National Research Council & Institute of Medicine (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. M. O'Connell, T. Boat, & K. Warner (Eds.). Washington DC: National Academies Press.

Variation in the ability of programs to work with this population

Although all the home visiting programs that participated in the pilot were using the HFI model, their ability to successfully engage and work with pilot clients varied widely. Some HFI programs were hit hard than others by factors such as the state budget impasse and staff turnover. One HFI program is operated by an agency that nearly closed due to the loss of state funding and almost all of the program's staff turned over.

Other factors that affected the ability of HFI programs to successfully engage and work with this population was their willingness to accommodate this population's unique needs. A good example of this is the use of creative outreach level. Several HFI programs kept pilot clients who were consistently missing visits on creative outreach well beyond the three-month minimum.

> The supports currently in place with this pilot make all the difference, it feels like we have "a pass" on not meeting productivity requirements with these families and allows us the freedom to devote more time for outreach/engagement. We can keep them on creative outreach longer, and we can still feel successful when we only meet with a family once or twice a month, versus weekly.

However, not every HFI program was as accommodating. One HFI program generally terminated services after 3 missed visits. Another placed clients on creative outreach but made little effort to engage them before terminating services as soon as three months elapsed. One parent whose services were terminated after she had been on creative outreach for three months shared her experience.

> It [home visiting] didn't leave a mark because I don't really remember much about her…We didn't do anything. It's not like we went out into the community or did anything or had real talks or nothing like that. It was just like, 'Oh, here's a packet.'

HFI programs that were willing to accommodate the unique needs of this population did so in a variety of ways. One was to keep cases open even after pilot clients had moved outside their catchment area. One home visitor visited her "couch-surfing" pilot client wherever was convenient for the young woman. Another continued working with a pilot client who was moved several times to different parts of the state. Home visitors and doulas from these HFI programs also kept their pilot clients' cases open while they were on-run.

Another way HFI programs accommodated the unique needs of this population was by creatively using their resources. After realizing that pilot clients in residential care would not be able to participate in their center-based childbirth and parenting class or use the "baby bucks" they earned during their home visits to "shop" in its pantry for items such as diapers, baby bottles, and car seats, one HFI program arranged to offer the class at the residential care facility and brought a mobile pantry to the residential care facility once a month.

Another HFI program had an incentive fund that could be used to purchase small gifts. A home visitor with this program discovered that a particularly young pilot client responded very positively to gifts, so she used gifts related to what they were working on to help build their relationship.

> I try at least every other, if not every, visit to be intentional and thoughtful about something she might like and then bring that to her…She had a lot of difficulty with emotional self-regulation. And we covered some different calming techniques, ways to regulate herself. I would bring her like a lavender oil and brought her a stress ball. Headphones so that she can relax with music [or] journal.

Maintaining fidelity to the HFI model can be a challenge

Home visitors and doulas often needed to deviate from what they typically do to engage and deliver services to pilot clients.

Enrollment difficulties

Although some young women were quite receptive to receiving home visiting services, that was often not the case. Home visitors typically reach out to potential clients a certain number of times before concluding that they're not interested. HFI programs participating in the pilot were asked to continue outreach efforts after they normally would have stopped because it was expected that this population would be especially difficult to engage. In some cases, those additional outreach efforts paid off. One HFI program continued outreach efforts for two months before a young women, who had experienced a series of crises after giving birth, finally enrolled. Had this occurred outside of the pilot, the program would likely have "deemed her not a good fit for HFI."

However, some home visitors felt uncomfortable when they were asked to continue outreach efforts to potential pilot clients after they normally would have stopped because HFI is supposed to be a voluntary program. One home visitor expressed concern that a pilot client who was initially unresponsive to outreach efforts might have "got kind of pushed into doing the program" because she missed about two thirds of her scheduled home visits.

Dealing with more pressing needs

The need to provide pilot clients with extra support often meant deviating from the HFI model. One supervisor described how her home visitors could not deliver home visiting services the way they normally did.

> There's no way we could expect anyone to do what they normally do as a Healthy Families [home visitor] with this population…We have not done like anything we're supposed to do in terms of the initial assessment. We...normally do [it] within the first 30 days, and it's been literally months, like half a year…Some of the core

> things…we're supposed to be doing for Healthy Families, it's a complete wash. We're not doing any of it...We barely use curriculum…so in that way it is completely different from what we're doing with other families.

This same supervisor went on to explain why delivering "services as usual" seemed inappropriate when pilot clients had more immediate needs to address.

> It's more just like what's the latest crisis? Let me support you and talk to you while you're ... actively in crisis...It's just like it would be a totally inappropriate thing to do, to be like, 'Oh, let me bring out this handout and go over it with you.'...I feel super conflicted because I just feel like something like this and more needs to be offered to these young women.

This sentiment was echoed by a home visitor who noted that neither she nor her pilot clients could focus on their parenting when their basic needs were not being met.

Applying the HFI level system

The HFI levels, which dictate how frequently client are supposed to be seen and affect caseload size, often proved unworkable when applied to pilot clients. For example, clients who recently give birth are typically placed on Level One and seen weekly by their home visitor. In some cases, home visitors put pilot clients on Creative Outreach, rather than moving them to Level One, because they were unable to have weekly visits.

One supervisor questioned whether their use of Creative Outreach was sustainable:

> Our use of Creative Outreach with these clients has been pretty unprecedented. I don't know if this collaboration [pilot] were to go away, keeping someone on Creative Outreach for like 8 or 9 months, I don't know if that's going to work in the regular Healthy Families world. For right now, we're just saying, 'Screw the rules, we're doing what we are doing, trying to engage, asterisk by their name, they are in the IPPYC pilot.' I'm worried, like [home visitor] has had a participant that she saw maybe once or twice and then she went on Creative outreach right away. She's been on Creative Outreach this entire time. And that's not going to change any time soon. I just feel like our use of Creative Outreach is really different and I just worry about when this [pilot] is no longer here."

Another concern raised by home visitors, doulas and supervisors about the HFI levels relates to the fact that all clients at the same level are weighted the same. Each level is assigned a weight (e.g., a Level 1 client is assigned a weight of 2 and Level 2 is assigned a weight of 1) that is supposed to reflect the intensity of services required and those weights are used to determine caseload size. Some home visitors, doulas, and supervisors suggested weighting pilot clients

more heavily than other clients at the same level because pilot clients required more intensive services.[41]

Providing Services to Clients with Children in DCFS Care

HFI programs do provide home visiting services to clients whose children are in foster care as long as the children's permanency goal is return home. HFI programs participating in the pilot continued to work with the five pilot clients whose children were in foster care and had return home permanency goals.

In addition to keeping their cases open, home visitors arranged to be present during the supervised visits that three of these pilot clients had with their children. Two home visitors attended supervised visits at the home of their pilot client or the foster home of their pilot client's child. Both of those home visitors modified what they did during these supervised visits. Recognizing that the parent might not know how her child is developing in some domains, one home visitor administered the Ages and Stages Questionnaire (ASQ), a standardized assessment of child development, but

> stuck to things she would be able to notice, such as how he was playing versus [his] sleeping habits, since I didn't want to make her feel like she was missing out on so much of his life.

A third home visitor not only attended the supervised parent-child visits but spent two to three hours each week transporting her pilot client to and from the daycare center where the visits took place. Although she used the travel time to talk with her client about being separated from her baby, the home visitor wondered how much impact she was actually having on the parent. Additionally, although the HFI program would normally have moved this parent to Level 2, the home visitor chose not to do so because she did not want the parent-child visits to become less frequent.

Two other home visitors continued to visit with their pilot clients whose children were in care, but their children were never present. This limited the types of activities in which the home visitor and clients could engage.

Home visitors and doulas routinely exceeded expectations

Home visitors and doulas often went "above and beyond" what they are expected to do to meet the needs of their pilot clients. The home visitor who spent two to three hours each week driving

[41] HFA standards released in January, 2018 begin to address this concern. The Special Services level is assigned a weight of 3 and the weight of the Creative Outreach level can range from 0.5 – 2.0.

her pilot client to supervised parent child visits was already described above. Here we present four additional examples of going "above and beyond.'

The first example involved a pilot client who needed childcare for her newborn so she could attend her college classes. Her home visitor, doula, and an intern work as a team to transport the newborn to a crisis nursery and the parent to college several mornings a week until the end of the semester. The parent and home visitor developed a close relationship during these commutes.

The second example of a home visitor going "above and beyond" involved a pilot client who was applying for a job. The home visitor brought the parent an Ann Taylor dress to wear to the interview, drove her up from her placement which was far outside the program's catchment area to the interview, and provided childcare for her baby while she was being interviewed. She was extremely proud when her pilot client was hired.

The third example involved a home visitor who continued visiting her pilot client while she was in juvenile detention. This home visitor explained how she used those visits and how those visits help build their relationship.

> I came initially just to communicate that I cared and to see how she was doing and see if she would like me to visit her there… even though baby wasn't there. And she was open to that. So, I came back. And I kind of just let her lead…and let her kind of use some reflective strategies in order to get her to think about what it is that she needs to do to get what she wants instead of me telling her…[M]y being able to be there and be not judgmental and supportive in a time that was difficult for her. That helped a lot to build that bond.

The final example involved a pilot client who was placed in a residential care facility several hours away from her home visitor and her baby, who was in foster care. Both the parent and her baby had been moved several times during the baby's first year of life. The home visitor stuck with her pilot client through all of these moves despite not being able to make regular visits with the parent and her baby together.

Pilot clients recognized when and how their home visitors went above and beyond expectations to provide support and viewed their actions as evidence that their home visitors "genuinely care."

Supports for home visitors and doulas

All the HFI programs that participated in the pilot had access to infant mental health consultants and FAN training. Both were helpful to home visitors and doulas in their work with pilot clients.

Infant Mental Health Consultation

The home visitors and doulas we interviewed appreciated the support the infant mental health consultants provided. They reported 119 consultations involving 32 pilot clients.[42] One home visitor reported feeling "refreshed" after meeting with her infant mental health consultant who gave her new ideas about how to approach upcoming visits with her pilot clients. Another described how the infant mental health consultant was able to help her when she was feeling overwhelmed.

> I was getting emotionally overwhelmed. Just hearing her story, and hearing her struggle, and her mom's struggle, and how history repeating itself… The infant [mental] health consultant was very helpful in helping me see things a little differently, in a more hopeful way.

Infant mental health consultation was critical for home visitors who found working with pilot clients more challenging than expected.

> Infant mental health consultation is a very important part. I don't think we were ready for the challenges [of the pilot]. We work with people who have trauma. We work with people who have mental health…We were not prepared for the extent of mental health issues that this population is dealing with. If it wasn't for the consultation and having that, it would be extremely difficult.

Use of the FAN Approach

Home visitors from several of the HFI programs talked about using the FAN approach in their work with their pilot clients.[43] One home visitor explained how she would focus on the feelings of a pilot client who appeared angry or frustrated before moving on to the activities she had planned. Moreover, although it is unlikely that the parents we interviewed were familiar with the FAN approach, some of the activities they described engaging in with their home visitor were reflective of the FAN's core processes. For example, the pilot clients discussed how their home visitors encouraged them to use self-regulation strategies, helped them become more attuned to their baby's cues, and provided them with a safe space to talk about their feelings.

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42 We did not ask about mental health consultation until July 2017.

43 Gilkerson, L., Hofherr, J., Heffron, M., Sims, J., Jalowiec, B., Bromberg, S., & Paul, J. (2012). Implementing the Fussy Baby Network Approach. *Zero to Three, 33*, 59-65.

Implications for Implementing the Family First Prevention Services Act

What the Child Welfare Subcommittee of the Home Visiting Taskforce could not have foreseen when planning for the pilot began was that the lessons learned from the pilot about delivering home visiting services to pregnant and parenting youth in care would soon have national significance due to a major shift in the federal child welfare policy landscape.

Family First Prevention Services Act

On February 9, 2018, the Family First Prevention Services Act (FFPSA) was signed into law. Among other things, this legislation allows states to claim federal Title IV-E funds to provide evidence-based prevention services to children who are "candidates for foster care" beginning in FY2020. Candidates for foster care include both children who are at imminent risk for out-of-home care placement but can remain safely at home or with relatives if prevention services are provided and youth in foster care who are pregnant or parenting.

Three broad categories of services are eligible for Title IV-E reimbursement under FFPSA: mental health treatment services; substance abuse prevention and treatment services; and, in-home parent skill-based programs which includes parenting skills training, parent education and individual and family counseling. Services, which may be provided for a maximum of 12 months, must be trauma-informed and meet certain evidence-based requirements for promising, supported, or well-supported practices. The first list of services and programs selected for review by the Title IV-E Prevention Services Clearinghouse includes three in-home parent skill-based programs that provide home visiting services: Healthy Families America, Parents as Teachers, and Nurse-Family Partnership.[44] As of June 2019, Nurse-Family Partnerships and Parents as Teachers had been rated "well-supported." Healthy Families America had not yet been rated.

Implications of the Pilot

The FFPSA has the potential to increase access to home visiting services among pregnant and parenting youth in care and other child welfare system involved families not only in Illinois but also in other states. The lessons we learned from the pilot can help state (and where relevant, county) child welfare agencies plan for and address the challenges they are likely to face engaging and delivering home visiting services to FFPSA-eligible populations.

[44] The Title IV- E Prevention Services Clearinghouse can be found at https://preventionservices.abtsites.com/

HFA Child Welfare Adaptation

In September 2018, about six months before the pilot ended, the national organization, Healthy Families America, rolled out an optional child welfare adaptation of its HFA model. Programs that choose to implement the adaption can enroll families referred by the child welfare system until the target child is 2 years old.[45]

As part of its rollout, HFA issued guidance for programs planning to implement the adaptation.[46] This guidance included a number of HFA's recommendations that are closely aligned with the lessons learned from the pilot.

- Remain involved with these families even if the target child is removed from home as long as reunification is the permanency goal and visit with both the parent and child as frequently as possible, which may involve attending supervised parent-child visits;
- Maintain smaller caseloads due to the intensity of services these families require and spread these families across staff to reduce burnout;
- Provide staff working with these families with ongoing training including training on the child welfare system;
- Provide infant mental health consultation for staff and supervisors in a group setting;
- Strengthen the relationship between the HFA program and the child welfare agency which may include trainings to increase understanding among child welfare staff that HFA is a voluntary program.

These are recommendations that programs planning to implement the adaptation are encouraged but not required to implement. Also included in the guidance HFA provided around the adaptation were a number of prohibitions---i.e., things HFA programs implementing the adaptation may not do.[47] Several of these prohibitions relate to issues that arose during the course of the pilot.

- Supervise visits between the child and parent(s) and/or transport to/from supervised visits;

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[45] See https://www.healthyfamiliesamerica.org/hfa-blog/2018/11/8/introducing-the-healthy-families-child-welfare-adaptation

[46] For a complete list of the recommendations, see http://files.constantcontact.com/8599d8b8201/38d58365-6366-4a5f-8c56-c8898fa3c232.pdf

[47] For a complete list of the prohibitions, see http://files.constantcontact.com/8599d8b8201/38d58365-6366-4a5f-8c56-c8898fa3c232.pdf

- Provide progress reports or program records to the child welfare agency without the parent's written consent (or a court order);
- Provide mandated services as part of a child welfare case plan or notify the child welfare agency that a family has terminated services because services are voluntary;
- Attend child welfare case staffings unless the parent is present and gives permission.

To date, the number of HFI programs in Illinois will implement the adaption is unclear. Although HFA created the adaptation so that fewer high-risk families would be ineligible for intensive home visiting services due to their target child's age, some of the HFI programs that participated in the pilot raised concerns about the impact that serving families referred by the child welfare system would have on their workloads given the intensity of services that some of these families need. They also questioned the feasibility of implementing the adaptation given the demands of their funders. One HFI supervisor summarized the situation this way:

> The adaptation sounds great but the onus is on the agency to find out about it. It's going to take some time and effort to figure out how to implement it and give yourself credit for the things you are doing that are extra. So I'm just saying it feels a little uphill without this [pilot structure] in place. I don't know…why the agencies would take on the extra work. I'm just trying to be realistic. HFA will understand, but what about the funders.

To the best of our knowledge, none of the other evidence based home visiting models currently being implemented in Illinois has a comparable child welfare adaptation. Nor do we know how those models might need to be adapted to successfully work with pregnant or parenting youth in care or with other child welfare system involved families.

Recommendations for Moving Forward

The Child Welfare Subcommittee of the Home Visiting Taskforce always intended for the pilot to be a launching pad for a more expansive effort to deliver home visiting services not only to pregnant and parenting youth in care but also to other child welfare system involved families throughout Illinois. The pilot has laid a solid foundation for this expansion.

Building on the foundation

Illinois can build upon the foundation laid by the pilot in at least four different ways. First, more HFI programs could begin to serve pregnant and parenting youth in care. Only nine of the 39 HFI programs in Illinois participated in the pilot, and none of those programs were in the southern region of the state. Second, non-HFI home visiting programs could begin to serve pregnant and parenting youth in care. HFI is one of several evidence-based models implemented in Illinois. Others include Nurse Family Partnership (NFP), Parents as Teachers (PAT), and Early Head Start - Home Based (EHS/HB). Third, the provision of home visiting services to pregnant and parenting youth in care could be expanded statewide. The pilot was implemented in just eight of the state's 102 counties. Finally, the target population could be broadened to include other families with child welfare systems involvement. One option would be to target intact families receiving services to prevent out-of-home care placement.

Below we discuss several major issues that arose during the course of the pilot that will need to be resolved if a successful expansion of home visiting services is to occur.

Need for training

One of the lessons we learned from the pilot is the importance of training. Home visiting program staff need training to successfully deliver services to pregnant and parenting youth in care. This training should familiarize home visiting program staff with DCFS policies and procedures related to this population. These include the services and resources that are available to pregnant and parenting youth in care, the education and employment programs for which youth in care may be eligible, and the Countdown to 21 program which is designed to support successful transitions to independence. It should also equip home visiting program staff to work with child welfare caseworkers and residential care providers.

Equally important, training should prepare home visiting program staff to work with pregnant and parenting youth in care. They need to understand how this population may require more support, be harder to engage, and have more trouble being consistent with their visits than clients they are accustomed to working with. In addition, to reduce the impact of staff turnover

or family leave on service provision, home visitors and doulas should be trained to develop a relationship not only between themselves and the client but also between the client and the program.

Training is also essential for child welfare workers whose caseloads include pregnant and parenting youth or who supervise pregnant and parenting youth in transitional living programs and residential care. This training should provide a clear understanding of what home visiting services are and how they are different from the services that parenting coaches provide. It should emphasize their voluntary nature and what that means for both pregnant and parenting youth who participate in these services and for the home visitors and doulas who provide them.

Balancing different approaches

Although both the child welfare system and the home visiting systems both want young mothers (and fathers) in foster care to be good parents, their approaches to providing support are very different. Home visiting services are voluntary and, with a few exceptions for mandated reporting, confidential. By contrast, the court may mandate participation in services for child welfare involved youth, participation in those services may be monitored, and there may be consequences for non-compliance. The differences between these approaches raises questions about whether and in what way home visiting services can be part of a service plan.

If home visiting services are included on a task list as part of a service plan, home visitors would need to furnish progress reports that can be submitted to the court. However, doing so is contrary to the voluntary and confidential nature of the home visiting approach. Moreover, pregnant or parenting youth whose task list includes home visiting services but who choose not to participate would be considered non-compliant by the courts, despite the voluntary nature of HFI services. Alternatively, if home visiting services are not on the task list, pregnant or parenting youth who participate will not be given "credit" for trying to improve their parenting. One potential solution might be to include home visiting services in the narrative portion of the service plan but not on the task list.

Information Sharing

Although home visitors and doulas do not require information about a young person's background and child welfare history to deliver services, they do need to be informed, in a timely manner, about events that could impact service provision. Specifically, it is important for home visitors to know if their clients have (1) experienced a placement change; (2) gone "on run" or returned to their placement; (3) been hospitalized, detained or incarcerated; or (4) had a child removed from their care. Additionally, it is critical for doulas to be notified when their clients are in labor so that they can be present and assist at the birth.

Child welfare workers including residential care providers also have information needs. In particular, they want to know whether young people are participating in home visiting services and, if so, what progress they are making as a result of their participation. Home visiting

programs may be reluctant to share that information without a client's permission because doing so might be seen as contrary to the voluntary and confidential nature of the home visiting approach. However, some home visiting programs might feel comfortable sharing information about the general topics covered during their visits.

We recommend establishing a clear policy related to information sharing between home visiting programs and child welfare workers. The policy should specify (1) information that *should* be shared; (2) information that *may* be shared; and (3) the conditions under which information sharing can take place (e.g., whether client permission is needed).

Monitoring and troubleshooting

The project's core team performed two functions that proved critical to the successful implementation of the pilot: monitoring whether visits were occurring and troubleshooting when they were not. These functions were essential to preventing the premature termination of home visiting services and to identifying barriers to engagement that needed to be addressed. If the core team had not performed these functions, fewer home visits would have been completed and home visiting services would have been terminated more frequently.

Consequently, we strongly recommend that any expansion of home visiting services to child welfare system involved families include the capacity to perform this monitoring and troubleshooting function. Someone needs to be monitoring whether services are being delivered and intervening when they are not to prevent premature termination. Someone should also be available to respond to questions from home visiting programs about DCFS policies and procedures or about specific clients.

The core team was able to provide this support to the pilot because TPSN had access to SACWIS and Child and Family ProFile and the project manager had access to some HFI program data as well as relationships the HFI programs. Thus, we also recommend that whoever performs the monitoring and troubleshooting functions have access to both SACWIS and home visiting program data.

Appendices

Appendix A

Initial IPPYC-HV Tip Sheet, May 2017:

IPPYC-HV
(Illinois Pregnant and Parenting Youth in Care Home Visiting)

For questions regarding the pilot- eligibility, history, partnerships, support- contact **Jaime Russell at 309.834.5296**

For questions regarding data entry, permission forms, and REDCap, contact **Elissa Gitlow at 773.256.5193**

For questions regarding difficulty reaching a referred participant due to a wrong or disconnected phone number or 3 unsuccessful attempts or difficulty reaching the legal case worker within a week, contact **Lisa Wilkerson at 773.239.9808**

For questions regarding the New Birth Assessment or the AAPI contact **Lashawnda Thornton at 773.239.9811**

Steps for the evaluation:

- At initial visit, get Chapin Hall permission form signed and fax it to Elissa at 773.256.5393. Chapin needs this form before any information can be entered into REDCap.
- After each visit (within 2 business days), enter visit information into REDCap.
- Please select Prenatal for the level if baby is not yet born.
- If a doula and a home visitor conduct a visit together only complete 1 REDCap entry but check both the doula and home visitor boxes so that both sets of questions appear.

Timelines and best practices to keep in mind:

- A Child and Family Team meeting occurs every 90 days in the life of a young parent in care's case. Within 5 business days of assignment of a case, the Home Visitor should send an introduction email/place an introduction phone call to the legal case worker and inquire regarding a case update and if there is a Child and Family Team Meeting already scheduled and if not, schedule one within 30 days of assignment so that it occurs within 90 days of pilot assignment.
- If there are two providers assigned to a case due to complexity (i.e. very young parent, severe mental illness), those providers should use the Child and Family Team Meetings to discuss their roles, a plan of who will provide what specific interventions and who will complete what assessments so that the parent does not complete duplicate assessments and services.

Revised IPPYC-HV Tip Sheet, August 2018:

FACT SHEET
IPPYC-HV
(Illinois Pregnant and Parenting Youth in Care Home Visiting)

If you have questions about the pilot or need to discuss significant events (e.g., hotline calls, child removals, family moves) with the pilot team, contact **Jaime Russell at 309.834.5296** Jaime.Russell@illinois.gov

If you have difficulty reaching a client or a client's case worker, contact **Lisa Wilkerson at 773.239.9808** Lisa.Wilkerson@ucanchicago.org. Also contact Lisa if you need help coordinating a joint visit with the caseworker or getting information about Child and Family Team meetings

If you have questions about the evaluation (e.g., permission forms, REDCap), contact **Elissa Gitlow at 773.256.5193** egitlow@chapinhall.org**.** She can also send you a link to the cross-training and evaluation training webinar.

Evaluation:

- Get the Chapin Hall permission form signed at the initial visit and fax it to Elissa at 773.256.5393. This form must be signed before any information can be entered into REDCap.
- Enter information into REDCap **(until April 30, 2019)** no more than 2 business days after each home visit. All completed, missed, and attempted visits, along with level changes, assessments, and referrals, should all be entered into REDCap.
- Remember to select Prenatal as the level for a client who is pregnant with the target child when she is referred. Subsequent pregnancies are not marked as prenatal, but rather remain as the level the client is on with the target child.

Timelines and best practices to keep in mind:

- Within 5 business days of assignment of a case, the Home Visitor should send an introduction email/place an introduction phone call to the legal case worker and inquire regarding a case update and if there is a Child and Family Team Meeting already scheduled and if not, schedule one within 30 days of assignment so that it occurs within 90 days of pilot assignment.
- Child and Family Team Meetings (CFTM) occur every 90 days in the life of a young parent in care's case.
    - Please work with Lisa Wilkerson if home visiting site is unable to get in contact with legal caseworker or is not getting response about CFTM dates.
    - Lisa Wilkerson can work to coordinate the initial visit between home visitor/doula, youth, and legal caseworker
- Level changes, missed visits, assessments, etc. are all entered into REDCap **(until April 30, 2019)** to paint a clear picture of services for pilot data research.
- Specific case details or significant events that site feels needs to be addressed or talked out with the pilot team- please contact Jaime Russell

    Examples: hotline calls, inability to see youth in their placement, family re-location, child removal or has not been available for home visits, lack of safe sleeping equipment in the home, etc.

Appendix B:

Topic Sheet for Congregate Care Staff

Participant Name: _____Date of visit: _____

Home Visitor Name: _____

Today we talked about:

_____
_____
_____
_____

Ideas/topics for next time:

_____

_____

_____

What is going well:

_____

_____